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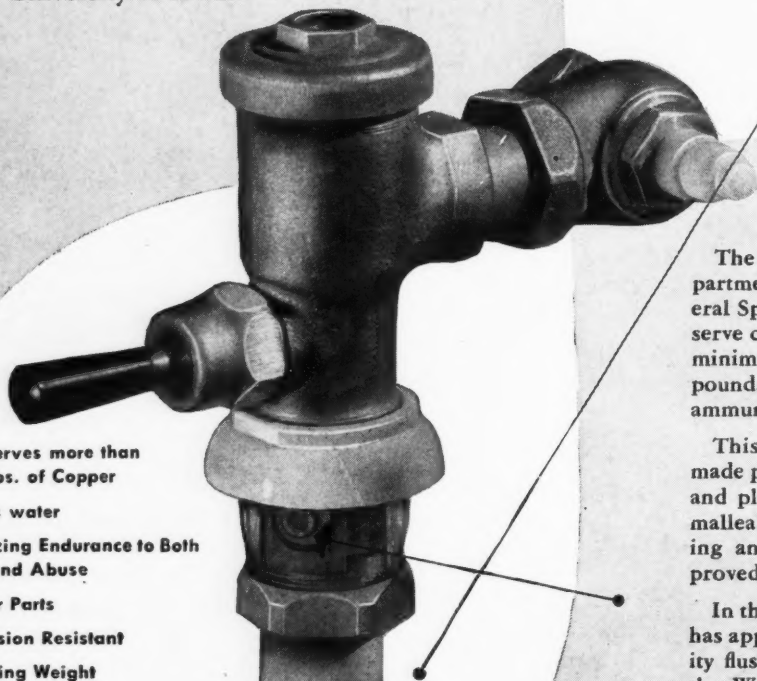
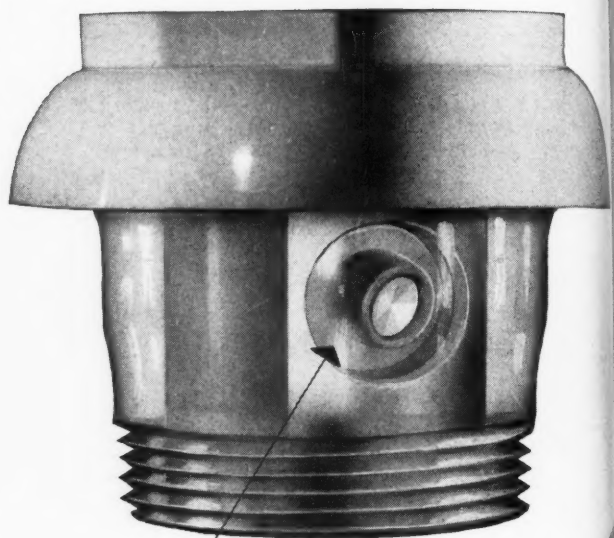
VOLUME 61

JULY 1943

NUMBER 1

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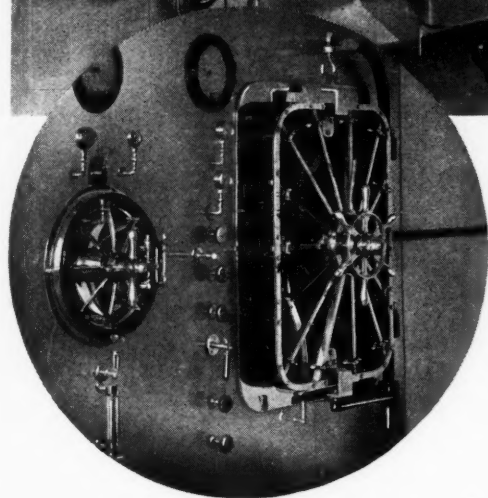
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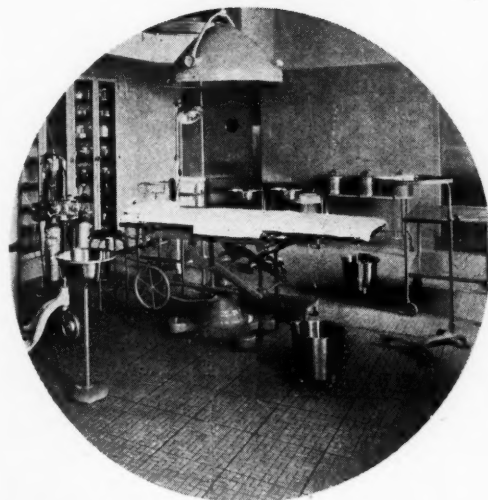


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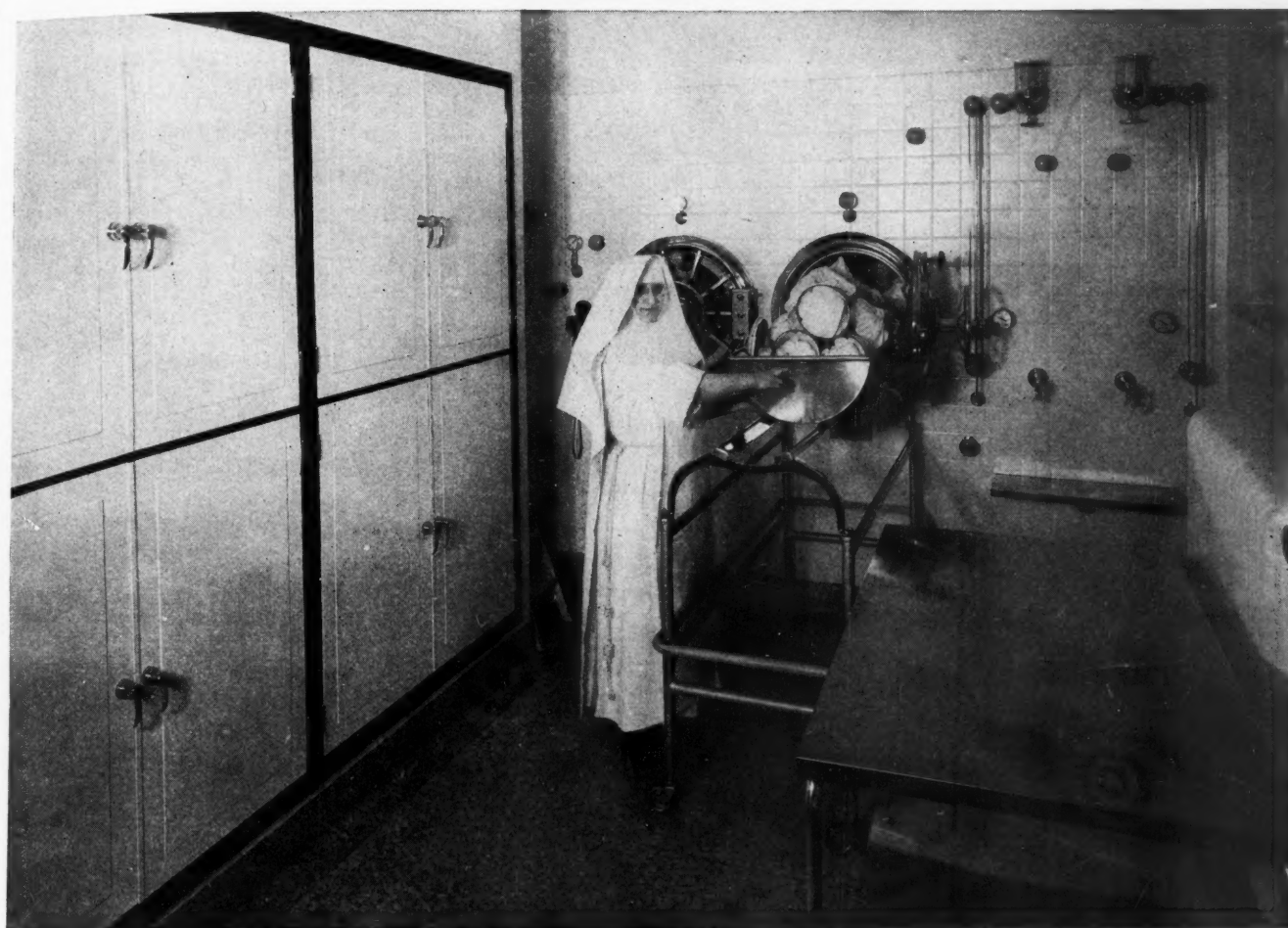
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THE ROVING REPORTER

To Children: From Children

No hospital bulletin is more welcomed by its readers than one bearing the title "The Children's Hour" whose contributors are patients in the pediatric department of the Bronx Hospital, New York City.

Circulation has been mounting steadily ever since it made its first appearance a year ago and today William B. Seltzer, superintendent, tells us that 300 copies are being distributed monthly not only to the children coming to the hospital's pediatric department but to the women's auxiliary, board of directors and other interested individuals.

"It's an excellent form of occupational therapy," according to Mr. Seltzer. "The children enjoy reading it because it is written by children of their own age; it also serves as a stimulus to other children on the pediatric service to write stories and poems."

This much having been said, it is only fair to quote from the Easter issue. The following editorial commentary is the work of Michael Cunnane, 12 years old.

"Easter is a season of happiness. People dress in their best suits and new spring outfits.

"Most children get basketfuls of candy and sweets. On account of the war there won't be much candy this year.

"I am in the hospital and will probably spend my Easter here, but it will be Easter just the same. If I were home I

would go to the circus, but as long as I'm getting well I don't mind being in the hospital.

"I wish everyone a Happy Easter."

No wonder that such editorial observations coupled with attractive pen and ink sketches resulted in The Children's Hour receiving first place in a recent contest for students' newspapers and magazines sponsored by the Columbia Scholastic Press Association.

Quilts From Tobacco Bags

Stamp collectors perhaps can understand the fervor with which the tobacco bag fad has gripped many patients at the Colorado State hospital, Pueblo. Until some time ago the discarded cloth tobacco sacks served no purpose.

Casting about for something interesting and useful for a woman patient to do whose capabilities were fairly limited, Carrie M. Rose, director of occupational therapy at the hospital, collected a few tobacco "empties" and suggested that the women make them into quilt blocks.

The patient made half a dozen floral basket stencils and started embroidering the designs on the blocks. Other patients became curious, interested and enthused. Now one group collects the bags from the wards, another bunch enjoys ripping them, others find pleasure in washing them, several press them and the stenciling takes the fancy of others. Finally,

many women now are making the blocks through long hours of embroidering.

A dozen different colors of thread are used and 288 blocks are required for one quilt. It takes about a year for one woman to complete a quilt, if she devotes about four hours a day to the work.

When a patient completes a quilt she is entitled to use it on her own bed.

The fad is not only utilizing waste material but is creating enjoyment for scores of patients.

Peck Plants for Victory

Visitors to Carson C. Peck Memorial Hospital, Brooklyn, N. Y., these days are likely to find Samuel D. Hunter, superintendent, with Miss Fitzsimmons, dietitian, and a nurse or two solicitously examining the garden in the rear of the buildings. They are estimating the damage of the previous night's wind and downpour upon the growing young plants in the hospital's victory garden.

For the duration, hospital patients and personnel must gaze upon vegetables instead of flowers and grass. Where previously marigolds and petunias bloomed in profusion, several hundred tomato plants now are staked and tended. As restful to look upon as was the velvety sod of the hospital lawn, rows of beans, peas, beets, carrots and corn are even fairer to the eye and far more satisfying to the stomach in war time.

If all goes well, and according to the latest farm reports from Peck everything points to bumper crops, the hospital larder will be replenished by fall and ration points will cause less worry for everyone concerned.

Paterson's Victory Cadets

"And these are our Victory Cadets!" Edgar Hayhow, superintendent of Paterson General Hospital, Paterson, N. J., is doing the introducing.

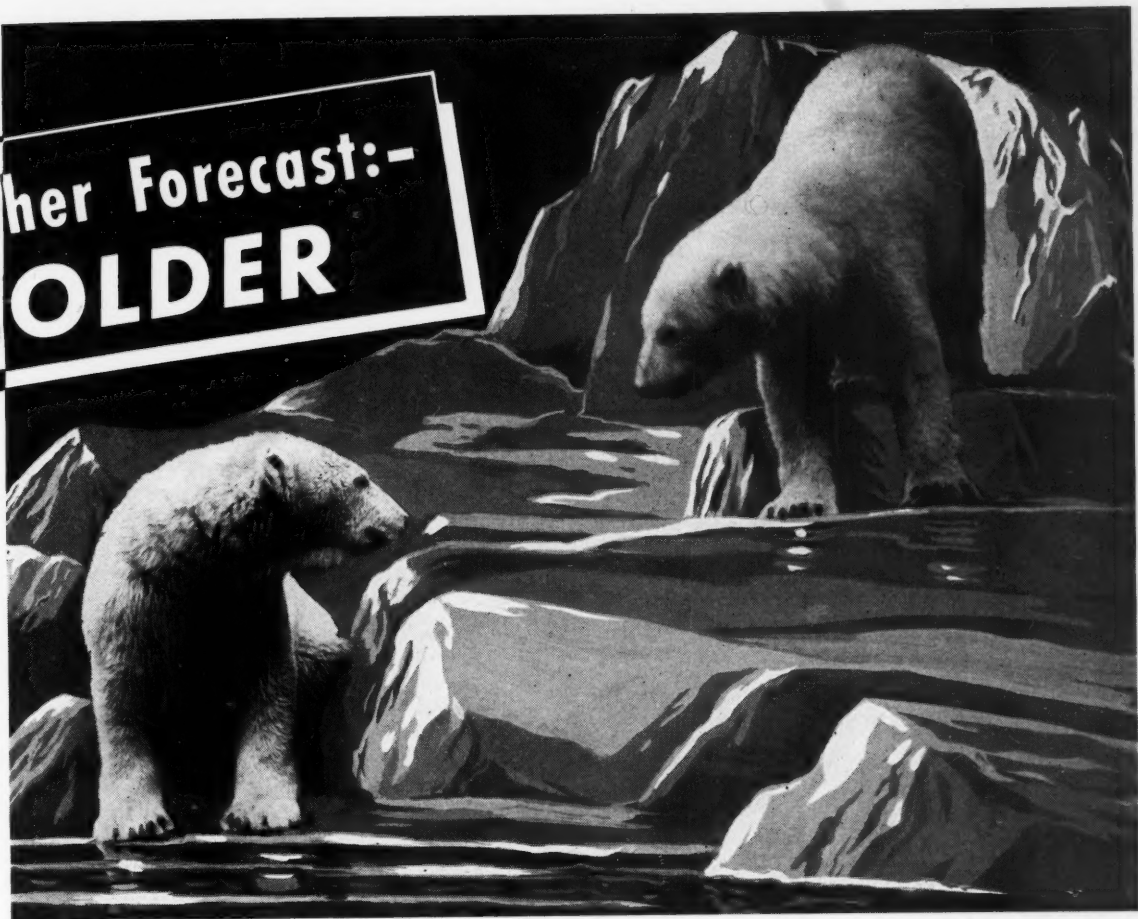
"These girls, pupils of the Eastside High School in Paterson, are learning the tasks of ward helpers and serve each afternoon, Monday through Friday, from 3:30 to 6:30, for which they are paid at the rate of 30 cents an hour."

Their presence resulted when Mr. Hayhow, Laura Robinson, supervisor of nursing, and Ellsworth Tompkins, principal of Eastside High School, put their heads together to help solve the nursing shortage. While working, the girls are studied as potential material for the nursing school and following this initiation into hospital life they are better able to decide whether they want to enter it professionally following their graduation from high school.



Miss Rose examines a tobacco sack quilt with embroidered flower squares.

**Weather Forecast:-
COLDER**



SOME folks may think it funny to talk about blankets in mid-summer . . . but it certainly is not too early to take stock and issue orders against coming requirements, especially in view of war-time conditions.

Government purchases are making it increasingly difficult to secure good blankets . . . and there is no substitute for a *good* blanket.

May we suggest, therefore, that you cover requirements now for blankets you will need next Fall?

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READER OPINION

At Liberty to Defy

Sirs:

Your regular feature "Looking Forward" for April 1943 contains a short article entitled "Accounting Again." You seem to imply that the answer to accounting problems is contained in the A.H.A. manual, "Hospital Accounting and Statistics." May I respectfully point out that your solution is an oversimplification of not just one but a group of difficult problems.

Before any marked improvement in small hospital accounting can take place administrators must be convinced of the necessity for adequate funds. In addition, hospitals will never be able to produce reliable cost figures until they adopt accrual (including inventory) accounting and provide in their books for depreciation of hospital equipment.

Too, hospitals have a shameful record in the matter of having their books and records audited regularly by competent public accountants. Even where hospitals have regular audits, often the purpose is merely to prove that all employees are honest. Recommendations intended to improve accounting efficiency are often frowned upon because the old ways of doing things "have always worked."

The most difficult phase of hospital accounting is the determination of costs except in those hospitals that have no out-patients and only one class of in-patients. Since you used the word "defy," I feel at liberty to defy anyone to show where the A.H.A. manual clearly sets forth a proper method of computing costs.

For instance, it is necessary to separate costs of caring for in-patients and out-patients (when both classes are treated) before one can determine the per diem cost for an in-patient. Exhibit E in part 2 shows a total cost of \$116,610 of which \$12,855 is applicable to out-patient service. The work sheet in part 5 uses the same total operating expenses but discloses an out-patient cost of only \$4295. Part of this difference lies in the fact that exhibit E charges \$2215 to out-patient service for x-ray, laboratory and other special services while nothing is charged to out-patient service for these categories in the work sheet shown in part 5. But why do 10 of the other 12 cost items appearing in both statements differ in amount?

I pose the question as to whether two "average hospital" accountants could independently produce comparable cost figures by the use of this manual.

Robert H. Reeves
Chief Accountant

Rochester General Hospital
Rochester, N. Y.

Answer for the Critic

Sirs:

After reading the editorial "Accounting Again," and the letter from Robert H. Reeves, chief accountant for Rochester General Hospital, Rochester, N. Y., I fail to see that you two disagree in any important particular. Mr. Reeves simply places greater blame for the "shameful record of hospitals" on the differences of administrators.

The introductory statement to the American Hospital Association's "Hospital Accounting and Statistics" also emphasizes this point in language that is not so direct. The absence of adequate cost figures is one of the greatest weaknesses in our American hospital system.

The specific criticism by Mr. Reeves of exhibit E in part 2 and the work sheet on page 80 in part 5 is apparently based on a misunderstanding. Exhibit E is a simple division of the total cost between in-patients and out-patients. The work sheet is an allocation of operating expenses to the income-producing departments in order to compare income with cost.

The \$12,855 is the cost of all out-patient service. The \$4295 is the cost of general out-patient department service, excluding x-ray department and laboratory services.

As a rule, the apportionment of cost to the income-producing departments, as illustrated in the work sheet, becomes less important as the hospital gets smaller. That is one reason why no attempt is made in part 9 to apportion such cost for the small hospital. In my experience this fairly simple basis of apportionment appears to work satisfactorily.

A more complicated basis of apportionment would be justified in a large hospital. The Cleveland Hospital Council and the United Hospital Fund of New York have developed such methods. The criticism that "Hospital Accounting and Statistics" does not go enough into detail in this particular may be justified.

Public confidence in the efficiency of management of hospitals, both governmental and voluntary, would be greatly improved if every hospital published a simple division of cost between in-patients and out-patients.

In any event, I am certain that I speak for Bob Reeves and all of us who are interested in the improvement of hospital accounting when I say that we are deeply appreciative of your editorial.

Graham L. Davis
Consultant

W. K. Kellogg Foundation
Battle Creek, Mich.

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SMALL HOSPITAL QUESTIONS

Films Retain Readability

Question: For how many years does a chest film retain its diagnostic value?—E.L.N., Wis.

ANSWER: If by "diagnostic value" is meant the period of time findings are visible on the film, the answer would be "many years." About ten years ago the material from which films are made was changed. The earliest films taken by the newer methods are quite unchanged. Films taken by the previous method have faded somewhat over a period of from ten to twenty years but, if originally good, are usually readable.

Some of the glass x-rays taken forty years ago can still be read, although the technics at that time were often poor.

The value of diagnostic information obtained from films, however, varies with the type of disease and is probably not relevant to this question.—WILLIAM H. OATWAY JR., M.D.

Superintendent Loyal to Board

Question: How can a superintendent be loyal to the medical staff and also to the board of trustees when she is aware that each group has definite and different ideas about the management of the hospital?—M.A.M., Ind.

ANSWER: This question relates itself to the fundamental organization of the hospital.

The board of trustees should definitely establish the standards and purposes of the hospital. This involves type of medical service and general administrative organization. The board of trustees creates the staff to carry out the purposes of the hospital. The superintendent is the agent of the board. Her duty is to carry out the purposes that the board has established. If this does not fit into the attitudes of the staff, a superintendent will, nevertheless, devote her loyalty to the board first. After that it becomes a problem for the board to settle.—JOSEPH G. NORBY.

What About Second Admission?

Question: Should hospitals give credit on second admission to the hospital if payments on first admission have stopped?—C.S.M., Ala.

ANSWER: This is a difficult question to answer with a categorical yes or no. Too many factors must be taken into consideration, for example, whether the payments are made regularly and then stopped because of a change in the economic status of the patient that made payments impossible. In such a case, the patient should be extended credit on a second admission.

However, if there is reason to believe that the promise to pay was made with little expectation that it would be kept and if the person in debt has a reputa-

Conducted by Gladys Brandt, R.N., Children's Free Hospital, Louisville, Ky.; Jewell W. Thrasher, R.N., Frasier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; William J. Donnelly, Greenwich Hospital, Greenwich, Conn., and others

tion for repudiating his obligations, I would then say that payment in advance, unless the second admission is of an emergency nature, should be insisted on. I would also advise that emergency admissions to the hospital be limited to admission on ward service.—WILLIAM J. DONNELLY.

Friendliness Without Intimacy

Question: In a fifty bed hospital, how friendly should the superintendent and his family be with employees and their families?—W.W.L., S. C.

ANSWER: The answer is not related to the size of a hospital but rather to the ability of the superintendent to remain free from snobbishness and at the same time avoid undue intimacy.—ADA BELLE MCCLEERY.

Payment in Advance

Question: Should a cash deposit be required on admittance to the hospital?—F.O., Mich.

ANSWER: I believe that asking for an advance deposit is an individual matter and that deposit requests should be made after determining the past experience of the hospital with the particular patient if one has had that previous experience or the apparent financial status or responsibility should the patient be new to the hospital. Deposit requests are "touchy" subjects and require great tact on the part of the admittance department personnel. I believe that the establishment of a hard and fast policy either way is not good administration.—ROGER DEBUSK, M.D.

Who Plans Meals?

Question: Who plans the meals in a general hospital of only 35 beds? Does the cook do this alone—with some help—or does the superintendent do it?—E.W., Mont.

ANSWER: Planning meals for the sick cannot be left to the cook since a cook seldom has had training in diet and disease. The superintendent would have to plan the meals if there is no dietitian.—MRS. JEWELL W. THRASHER.

Vacations for Department Heads

Question: What is the average vacation granted for (1) department heads, (2) nurses, (3) office employees, (4) domestic and maintenance employees?

ANSWER: 1. Department heads (based on a full year's service) receive a vacation allowance of one calendar month.

2. General duty nurses are allowed four weeks; instructors, supervisors, head nurses, assistant head nurses—in other words "faculty"—receive one calendar month.

3. Office employees receive two weeks.

4. Domestic and maintenance employees receive two weeks.

Two weeks is a *minimum* paid vacation for one year's service.—GEORGE PECK.

Vote for Semigloss Paint

Question: Which is the better type of paint for walls, flat or semigloss?—F.O., Mich.

ANSWER: Because it is more sanitary and easier to maintain, semigloss paint is preferable to a flat finish for hospital walls. Care should also be taken in using it to select only the best quality, for today help is scarce and unreliable and hospital rooms cannot be spared for "doing over" except when essential.—R. P. S.

The Value of Water Paint

Question: Are hospitals using water paint for halls and patients' rooms? Is it washable? Can it be painted over at a later date without being removed?—L.W.C., Pa.

ANSWER: Comparatively few institutions use water paint. It can be washed with a fair degree of success, with the exception of that type known as calamine paint, and can be painted over about four or five times. Where it is desirable to apply regular paint to the surface, best results are secured by using a coat of self-sealing, oil base, flat wall paint. The best types of cold water paint comprise a casein paint or a resin emulsion.—R. P. S.

How to Feed Employees

Question: What are other small hospitals doing in regard to feeding the help? Do employees get exactly the same kind of food as patients and nurses with all the special entrees, or are they fed a plainer fare?—A.E.D., Mich.

ANSWER: At the request of our laundry and housekeeping employees an increase in salary was given to them, with the understanding that no meals would be served them. The hospital furnishes only milk and coffee.

As to our other employees, such as maintenance men, office help and nurses' aides, they are served the same kinds of foods as are patients and nurses. We make no difference in menus with the exception of special diets.—MRS. ELIZABETH NICHOLS, R.N.

HEADLINE NEWS

JULY 1943

New Wagner Bill Would Include Medical Care and Hospital Service

WASHINGTON, D. C.—A third legislative attempt to bring hospital care under the federal Social Security Board is embodied in the identical bills introduced on June 3 by Senators Robert Wagner of New York and James E. Murray of Montana (S.1161) and Representative John D. Dingell of Michigan.

This bill is broader than its predecessors, the Green and Eliot bills, however, because it proposes to include medical service as well as hospital care.

In addition, the bill would bring employees of hospitals and other charitable organizations as well as farmers, domestic servants and self-employed persons under the various benefits of the Social Security Act.

The act is not only broadened to include these new groups totaling about 15,000,000 people but is extended to include protection from the costs of maternity care and temporary and permanent disability, as well as unemployment and old age.

In addition to the establishment of a federal system of medical and hospitalization benefits, the bill seeks to encourage the advancement of knowledge and skill in preventive and curative medical care.

The medical and hospital benefits are provided by a rewriting of title IX of the act. This puts the administration of these benefits in the hands of the surgeon general of the U. S. Public Health Service while the funds are to be collected by the Social Security Board. Everybody who is insured under the act and his dependents are to receive general and special medical, laboratory and hospital benefits. Hospital benefits are limited to thirty days unless money permits an increase up to a maximum of ninety days.

The surgeon general can make agreements with governmental or "private" agencies and individuals to use their facilities or services. He is to appoint a national advisory medical and hospital council with himself as chairman and 16 other members to be selected from panels of names submitted by the professional and other organizations concerned.

This council can advise the surgeon general regarding professional standards, methods of organization and coordina-

tion, hospital standards, methods of payment, grants-in-aid for professional education, research and similar matters. He is not bound to accept the advice.

Acute disease hospitals would be paid from \$3 to \$6 per day for the first thirty days of care and from \$1.50 to \$4 for additional days. Chronic care would be compensated for at the rate of \$1.50 to \$3 per day. Individual hospitals might be paid on a cost basis within these limits.

The surgeon general, by the bill, is directed to set up a panel of participating hospitals in accordance with standards prescribed by him after consultation with the council. These standards may vary for urban and rural areas and in various parts of the country.

Section 910 provides that the same benefits granted to insured persons may be granted to other individuals if payments on their behalf have been made or promised to the trust fund. This may permit the inclusion of state, municipal

(Continued in Column 3)

DON'T PRINT THAT!

Editors of all medical and hospital publications have been warned by the Office of Censorship in Washington that it is exceedingly inadvisable to publish uncensored letters coming from doctors in service, particularly when they include the addresses of the physicians.

In several instances such letters have served to reveal the identity of troops overseas. The Code of Wartime Practices for the American Press calls attention to the danger inherent in this practice.

The Office of Censorship states:

"All publications are particularly requested to avoid identification of soldiers with their troop units when they are overseas, about to embark or on defense (as distinguished from training) activities in the United States.

"In the case of naval personnel the identification of ships and bases is to be especially avoided.

"When in doubt, editors will do well to get a direct response from the Office of Censorship regarding the release of any special item."

and county employees or of the indigent.

A unified public assistance program is proposed in section 1201. This provides for federal payments of 50 to 75 per cent of the cost to states with approved public assistance plans. An important part of this program is that the definition of "assistance to needy individuals" includes not only money payments but, where so provided in the state plan, medical and rehabilitation services for needy individuals.

In discussing the health benefits, Senator Wagner stated that his plan is not like the Beveridge plan for a system of socialized medicine, with all doctors required to be salaried employees of the government. S.1161, the senator maintained, assures complete freedom of choice of doctor and hospital by the patient and freedom of medical practice and types of remuneration for the doctor and the hospital. No doctor is forced into the insurance system or is on a salary status.

Arrangements for obtaining medical, laboratory or hospital care, according to the senator, would be essentially as they are now in this country, except that payment for the care and services would be made out of the insurance fund, built up through the insurance premiums paid by the individual and his employer. Three per cent of wages and salaries are set aside in a special account to meet these insurance costs. Voluntary hospitals would, of course, be eligible to participate in the plan.

Nonprofit group medical or hospital plans may also be utilized, the senator said, in carrying out the program, and they would be in a position to offer supplementary health protection for families desiring more than the basic social-insurance benefits guaranteed under the bill.

File Rationing Forms by July 5

WASHINGTON, D. C.—A simplified postcard-sized ration allotment form has been prepared by O.P.A. for use of institutional consumers in applying for rationed foods for the two month allotment period beginning July 1.

Hospitals in Group III need only supply one new item of information, the number of persons served during April and May. "Gross dollar revenue" need not be submitted since hospitals usually cannot separate revenue from patients that is attributable solely to food service. The mailing deadline is July 5.

Cooperation of Hospitals on New Textile Order M-328 Asked by Jones

By EVA ADAMS CROSS
Washington Representative, The MODERN HOSPITAL

WASHINGTON, D. C.—A new order cross-cutting the entire textile field was issued by W.P.B. on June 1. The order, M-328, clarifying the priority pattern for the textile, clothing and leather industries was designed to restrict the use of preference ratings for distribution of these products to the most essential purposes and to eliminate their use for all other purposes.

An official of the Textile, Clothing and Leather Division of W.P.B. assured Everett W. Jones that as a result of Order M-328 the producers and prime distributors of cotton textiles will be better able to distribute equitably vast quantities of textiles heretofore covered by priority ratings only. "In due time," he explained, "all hospitals and public institutions will find that contact with their normal sources of supply will be all that is necessary to obtain reasonable quantities of goods."

Urgently requesting the cooperation of the hospitals, Mr. Jones pointed out that in the matter of both patients' and employees' hospital clothing the manufacturer under the terms of M-207 still has the A-2 priority to obtain the textiles with which to make hospital clothing. Because of this, and in accordance with the new order, M-328, no distributor, dealer or manufacturer has any right to ask for or accept a priority rating from the hospitals for hospital clothing.

W.P.B. Forms Will Be Simplified With New Identification System

WASHINGTON, D. C.—Identification of War Production Board forms will be simplified by a new system that is being put into effect as present stocks are exhausted and reprinting becomes necessary, it has been announced by W.P.B.

All forms in the WPB, PD, UF and RD series and many in the CMP series will eventually bear only the initials WPB, followed by a new serial number. Letters of instruction will be identified by the designation WPBI and assigned serial numbers. Each form as it is re-numbered will carry both old and new designations until users become familiar with the new identification.

It is expected that several months will elapse before all forms will bear the new numbers. A conversion table showing both the new numbers and the old designations of some orders affecting hospitals is shown in the adjoining column.

If, after thirty or sixty days' trial, he concluded, evidence shows conclusively that hospitals will really be handicapped in not having a special priority, the matter will again be taken up with the textiles division.

Cancellation of all outstanding ratings, with certain clearly defined exceptions, was immediately effective upon issuance of the order. Among the exceptions of interest to hospitals are those ratings assigned by M, P or L orders. Included among others are M-73, M-298, P-116, M-134 and M-207. The canceled ratings include all those assigned or extended under CMP regulations unless to fill military orders; those assigned by any W.P.B. order not specifically exempt from M-328, and any other ratings assigned by W.P.B. unless they specifically conform with the provisions of M-328.

Uncontrolled use and extension of ratings assigned by W.P.B. orders, authorizations and CMP regulations resulted in many ratings being used without regard to their original purpose. For example, ratings assigned for maintenance, repair and operating purposes under CMP 5A and under certain P orders were being used to procure textile fabrics for clothing and other purposes on the theory that such use was properly an "operating" one. Maldistribution inevitably resulted.

Further Revision of CMP-5A Imminent, Officials Declare

WASHINGTON, D. C.—Although CMP Regulation No. 5A was amended June 9, it is the opinion of those in authority that other changes are imminent. The exclusion of professional capital equipment items, Everett W. Jones pointed out in an interview June 14, from the terms of the order had little effect. Most of such equipment purchased by hospitals costs in excess of \$100 and never was procurable under the order.

In spite of the fact that hospital and professional equipment up to the \$100 value can no longer be obtained on the AA-1 priority rating of the order, maintenance and repair parts for this type of equipment may still be had under the terms of the regulation.

Numerous individuals, said Mr. Jones, labored under the erroneous impression that equipment up to any value could be purchased under CMP-5A and, as a consequence, many violations of the order occurred.

Peru Gives 100 Pounds of Quinine

WASHINGTON, D. C.—A gift of 100 pounds of quinine was presented to the President by President Manuel Prado of Peru and turned over to the national quinine pool on May 28. Charles R. Bohrer, assistant secretary of the American Pharmaceutical Association, announced that the quinine collected at the association's building now amounts to 46 barrels and 37 cases.

W.P.B. Conversion Table

Subject	Present Number	W.P.B. Number
Air-conditioning machinery equipment: application to purchase, install.....	PD-830.....	2449
Application by laboratory for serial number.....	PD-107.....	167
Blanket priorities and project rating: application.....	PD-200.....	617
Boilers.....	PD-665.....	1790
Cast-iron boilers, low pressure.....	PD-639.....	1510
Civilian use, essential: application.....	PD-1A.....	541
Commercial cooking equipment.....	PD-638; 638A.....	1509; 1529
Commercial dishwashers.....	PD-638A.....	1529
Domestic mechanical refrigerators: application to purchase.....	PD-427.....	882]
Floor maintenance machines: application to purchase.....	PD-722.....	1843]
Fluorescent lamp bases: manufacturers' and reclaimers' allocation application.....	PD-532.....	1200
Laboratory equipment: application for use.....	PD-620.....	1414
Laundry machinery: application for authority to purchase.....	PD-418.....	924
Mechanical refrigerators: application to purchase.....	PD-427.....	882
New laundry equipment: application for authority to purchase.....	PD-418.....	924
Office machinery, used: application to acquire.....	PD-688.....	1688
Plate warmers.....	PD-638; 638A.....	1509; 1529
Riboflavin: allocation applications.....	PD-600, 601.....	2945
Scales: application to purchase or rent.....	PD-857.....	2581
Stokers: application to purchase.....	PD-668.....	1612
Used boilers or turbines: application for release.....	PD-677.....	1706

More Army Nurses Are Urgently Needed, Warns Colonel Blanchfield

By EVA ADAMS CROSS
Washington Representative
The MODERN HOSPITAL

WASHINGTON, D. C.—The need for more members of the Army Nurse Corps is still urgent, declared Col. Florence A. Blanchfield, formally appointed superintendent of the Army Nurse Corps, June 1.

Equitable distribution of nurses, Colonel Blanchfield pointed out in an interview June 16, will alleviate acute nurse shortages in many areas. The nursing unit of the War Manpower Commission, she added, will aid in straightening out the entire situation not only through judicious allocation of nurses and the effecting of their orderly withdrawal from civilian activities but also in the interpretation of essential civilian needs to the military services.

Colonel Blanchfield has no fear of a surplus of nurses in case of a sudden cessation of the war. Public health services throughout the United States, she maintains, were actually only getting started at the outbreak of hostilities. She predicts that after the war the demand for nurses in public health alone will absorb many of them. Moreover, the Veterans' Administration will have a long continued need for nurses and the tremendous expansion of hospitalization programs, the requirements of industry and the fact that the Army will not be greatly reduced for many years to come all point to a long-time demand for nurses.

Army nurses are now stationed at 35 bases outside the United States as well as at 537 stations within the continental limits. With the growth of the nurse corps to keep pace with the rapidly expanding Army, additional courses in military orientation and physical conditioning are being established throughout the nine Service Commands for nurse corps units. Actual bivouac experience is sometimes set up for overseas units to accustom the nurse to working under the tent conditions of field hospitals.

The highest peak in nurse recruitment for the War Reserve of the Red Cross nursing service was reached in March when 2900 nurses signed up for the Army and Navy Nurse Corps.

Philadelphia Adopts Code

The Hospital Association of Philadelphia has adopted a code for giving information to the press based on the rules prepared by the Cleveland Hospital Council. Some changes were made in the code to adapt it to local needs.

Canadian Health Insurance Bill Supported by Hospitals and Doctors

A comprehensive health insurance plan is now being considered by a special committee on social security of the Canadian parliament in Ottawa and will probably be passed at either this session or the next, in the opinion of those who are best informed on the measure.

The proposal has the support in principle of the hospitals, medical profession, nurses, dentists, manufacturers' associations and other groups.

The measure involves joint dominion-provincial action. The provinces would administer actual health insurance programs with the Dominion making financial grants and setting the pattern for federal approval.

Preventive medicine and public health education receive unusual stress in the proposed plan, which was prepared by an advisory committee on health insurance appointed in February 1942. The advisory committee was headed by Dr. J. J. Heagerty, director of public health services of the Department of Pensions and National Health. The report was presented to Parliament on March 16 by the Hon. Ian Mackenzie, Minister of Pensions and National Health.

According to Dr. G. Harvey Agnew, secretary of the Canadian Hospital Council, the plan would cover the entire population—employed and unemployed, master and servant, farmer and industrialist, the working adult, the aged, the indigent and children. Provinces may, if they wish, limit benefits to those persons having less than a specified income. Cash benefits are not included.

Every person would receive full medical care, including diagnosis and curative treatment from general practitioners and specialists, hospital care, nursing care and partial dental care. Free choice of physicians is provided.

It is expected that there will be full use of voluntary hospitals and free choice of hospital. Ward accommodations will be the standard but private or semi-private service may be had by paying the difference. Drugs will be supplied, probably from a comprehensive list of standard medicines.

Because of the inadequate number of dentists available, dentistry will be incomplete at first, being given without charge only to children up to a certain age. Traveling dental clinics to serve rural areas are envisaged.

Provinces will not receive financial aid from the Dominion unless they maintain a general public health program approved by the Dominion that must include 24 specified services.

In addition, six services may be included, namely, free treatment for tuberculosis, for mental disease and defects, and for venereal disease; training in public health for physicians, engineers, nurses and sanitary inspectors; special public health investigations, and a physical fitness program for youths.

It has been estimated that employees and assessed contributors (farmers and property owners) would contribute about 39 per cent of the cost and employers would pay 9 per cent. The remaining 51 per cent would be shared between the Dominion and provincial governments from general taxation.

No provision is made in the bill for the continuance of the three Blue Cross plans now functioning in Canada. On March 31 these plans together had an enrollment of approximately a third of a million persons.

Bolton Bill Signed; Advisory Committee to Outline Procedure

WASHINGTON, D. C.—Passing both houses without a dissenting vote and signed by the President June 15, the Student War Nursing Reserve Bill is now accomplished legislation.

The first meeting of the advisory committee of the Student War Nursing Reserve set up by the Bolton-Bailey Act was called June 25 in Washington, D. C., to consider details of rules, regulations and standards for operation of the reserve.

The war emergency project will be administered under Dr. Thomas Parran, surgeon general, U. S. Public Health Service. Lucile Petry has been appointed director and Mrs. Eugenia Spalding, associate director, of the new program. Both are on the nursing education staff of the U. S. Public Health Service. Miss Petry is on leave of absence as dean of the Cornell University School of Nursing.

Money will be paid quarterly in advance in the amounts estimated in order to enable hospitals to carry out the provisions delegated to them by the act. Subsequent allotments can be increased or decreased, depending upon how accurate the initial estimates have proved to be.

Rules and regulations for postgraduate and refresher courses under the Bolton-Bailey Act will be similar to those that have been in operation under the "training for nurses" (national defense) law.

Arrowsmith Is New Head of O.P.A. Hospital Unit, Food Rationing Section

By EVA ADAMS CROSS
Washington Representative, The MODERN HOSPITAL

WASHINGTON, D. C.—Leighton M. Arrowsmith, administrator for the last fourteen years of St. John's Hospital, Brooklyn, N. Y., heads the new hospital unit of the institutional user branch, food rationing division of the O.P.A., it was announced by Archie Palmer, associate director of the food rationing division, June 18, in an exclusive interview with The MODERN HOSPITAL.

Promising an early announcement of the complete definitive plan, Mr. Palmer declared that the Office of Price Administration has for several months been conducting investigations and studies in collaboration with medical authorities, hospital administrators and dietitians. Their entire effort had been directed toward developing a uniform procedure for the granting of supplemental allotments and the determination of amounts required for specific diseases.

In the formulation of the institutional user food rationing program, the special feeding problem of hospitals was recognized, Mr. Palmer pointed out, through the inclusion in the regulations of the provision (Section 11.6 of General Ration Order 5) for supplemental allotments "to meet the dietary requirements of the persons living and receiving care there." By this provision, hospitals were removed from the general category of other institutional users. The provision should, in the meantime, enable hospitals to obtain the necessary supplemental allotments so that no patients shall suffer from dietary deficiency.

No supplemental allotments for hospital employes may be granted under this provision; they are treated the same as any householder, consumer or patron of a public or private eating place is treated.

In determining the amount of the supplemental allotment of processed foods and of the commodities covered by Ration Order 16, the local board will take into consideration the availability of fresh fruits and vegetables and unrationed substitutions, such as poultry and fresh fish, as well as the physical facilities of hospitals to process and store such foods.

When applying for their July-August allotments of rationed foods, hospitals needing supplemental allotments to meet the dietary requirements of their patients are advised by Mr. Palmer to call the attention of their local board specifically to the provisions of Section 11.6 of G.R.O. 5.

On June 2 canned evaporated and condensed milk were included among the foods rationed under Ration Order 16. Although this action is designed to reduce drastically the use of canned milk whenever a satisfactory substitute is available, priority in its use is given to infants and invalids on special diets prescribed by their physicians.

A.M.A. Urges Hospitals Not to Approve Uniform Blue Cross Contract

The house of delegates of the American Medical Association meeting in Chicago on June 7 to 9 adopted resolutions urging the American Hospital Association to withhold approval of the uniform comprehensive Blue Cross contract proposed by the Hospital Service Plan Commission because it "includes certain medical services as a part of hospital care."

The delegates protested violently against hospitals engaging in "the practice of medicine," particularly radiology, pathology and anesthesiology, and said that the "public should be educated to realize that the hospital-created monopoly control of radiologic or any other service as a source of profit beyond the normal provision for replacement, department development and proper proportion of over-all costs of operation of the hospital should not be permitted."

"The hospital cannot use per diem charges against all the hospital patients to support a radiologic or other department devoted to creating bargains in radiologic or other services in order to make group hospital insurance more attractive."

The delegates went further and demanded a complete change in the accepted form of hospital organization, stating that "in the relationships of the medical staff and the board of directors of a hospital there should be no intermediary. The staff should have direct access to the board." Thus, the hospital administrator is to be by-passed.

Two new councils were established. The one that aroused most public interest is a council on medical service and public relations to study the rendition of medical care to the American people and to suggest improvements. The other new council is on legal medicine and legislation. Each council is to consist of six members.

Hospitals Can Obtain Sunday Deliveries, O.D.T. Announces

WASHINGTON, D. C.—O.D.T. Order 17, issued May 24, drastically curtailing deliveries, including Sunday deliveries, affects primarily the Eastern Seaboard.

Some hospitals were at first hard hit by nondelivery of milk on Sunday. The Office of Defense Transportation has informed Everett W. Jones that hospitals lacking sufficient storage capacity in their refrigerators for storing a supply of milk over week ends can obtain Sunday deliveries.

Other special provisions helpful to hospitals are the exceptions made in the mileage reduction requirements and delivery restrictions.

"No person shall cause to be made by motor truck and no motor carrier when operating a motor truck shall make any special delivery, *except to hospitals.*"

Another exemption to the restrictions is: "Any motor truck operated in emergencies exclusively for the purpose of making deliveries of medicines or other supplies or equipment necessary for the protection or preservation of life, health or for public safety. . . ."

Among special or general permits is the general permit "issued by this office to meet specific needs or exceptional circumstances or to prevent undue public hardships."

"Sit Tight" on Converting to Coal, O.P.A. Official Says

WASHINGTON, D. C.—An official of the Fuel Rationing Division of O.P.A. on June 14 told the Washington correspondent of The MODERN HOSPITAL that further conversion in their heating arrangements from oil to coal on the part of hospitals is now debatable. Much depends on where the hospital is located.

In some sections, this official said, wood may be rationed, in others, coal. However, he advised hospitals to convert from oil *if* they have an available alternate fuel. Another hospital authority in Washington advises hospitals to "sit tight" for a few weeks.

The official declared that whatever the situation may prove to be, the O.P.A. will continue to give special consideration to the needs of hospitals. He praised hospital administrators for their patience and willingness to cooperate. Careful study has been made of last year's complaints, he said, and with a year's experience to its advantage, O.P.A. is working out a new program based on the old that is designed to aid the consumers and also to conserve, in every way possible, fuel oil supplies.

LOOKING FORWARD

Putting Money Where It Pays

THE house of delegates and assembly of the American Hospital Association will probably be asked at the Buffalo meeting to approve an amendment to the association's by-laws making a substantial increase in the dues.

At present the maximum dues for a hospital, no matter how large, are \$75 per year. In almost any other type of organization, an individual member with a total budget as large as that of a large hospital would pay dues of five or ten times this amount.

More important, however, is the fact that the American Hospital Association definitely needs more money if it is to carry its responsibilities successfully. Each of the councils of the association and many of the committees have been handicapped for years by lack of sufficient administrative and clerical assistance and inadequate funds for publication. Often, committees have been sharply criticized by members because of apparent inactivity or lack of interest. Yet the committee was doing valiant work when one considers the handicaps resulting from lack of funds and personnel under which it carried on.

The Hospital Service Plan Commission has a full-time staff of competent, skilled persons at the headquarters office. For the past several months the Council on Governmental Relations has had a full-time secretary in the director of the Wartime Service Bureau. But the other five councils—administrative practice, professional practice, planning and plant operation, public education and association development—have to get along on volunteer services or the scraps of time that can be given them by the overburdened executive secretary and his assistants. Each one of these councils could well use the full-time services of a qualified executive officer; if this is now impossible perhaps at least two or three full-time persons could be shared by the various councils.

The most direct and surest way to raise the funds needed by the association is to raise the dues substantially. Hospitals throughout the country have already shown unmistakably that they are ready and willing to pay increased dues by their overwhelming response to the appeal for funds to support the Wartime Service Bureau. Unquestionably, they will approve the further request of the board of trustees.

Warning

IT WAS announced in our June issue that the Los Angeles County Hospital had installed a 700 bed pay patients' section in order to meet the present shortage of beds in the voluntary hospitals of that area. The voluntary hospitals should take warning from such action. Once it is begun, it will be difficult indeed to stop.

A county hospital of high medical standard and attractive physical structure can quickly put the neighboring voluntary hospitals out of business. All that is necessary is to persuade the authorities of local government that the county hospital should continue to care for pay patients and that the county can subsidize this service to a small amount.

The lower costs that generally characterize large, well-managed county hospitals plus a direct or indirect subsidy from tax funds will make it easy for the governmental institution to offer good care at rates considerably lower than most voluntary hospitals can afford.

Voluntary hospitals should realize that this threat to their future existence is so important that every effort should be made now to avert it. Probably there is not a voluntary hospital in any of the most crowded communities that cannot somewhere find room for more patients. Of course, it is hard to find personnel. But if the governmental hospital can find employees, so can the voluntary institution.

One of the major obstacles to full use of voluntary facilities is that many hospitals do not want to admit patients of doctors who are not on their regular staff. In this emergency period, methods should be found to overcome this situation. Some hospitals have already arranged to extend staff courtesies to the medical staffs of their neighboring hospitals. Such an arrangement, to be effective, must be administered wholeheartedly. A niggardly spirit will make it valueless.

Pattern for Postwar

WHEN Wendell Willkie had been home for several months he reduced to a small book the various thoughts that had come to him in his forty-nine day trip around the world. While the trip itself

fulfilled Jules Verne's predictions, the thoughts that passed through Mr. Willkie's mind were probably far beyond the range of even Mr. Verne's lively imagination. But so well has Mr. Willkie expressed the aspirations of millions of this globe's citizens that his book has become a phenomenal best seller. Had not the War Production Board short-sightedly shut off the supply of paper, "One World" might soon rival in circulation that perennial best seller, the Bible.

If Mr. Willkie mentions the word "hospital" anywhere in his book, it is purely incidental. Yet his subject is of direct and immediate concern to hospital administrators as well as to all others in executive and managerial positions. He charts for us, in graphic and convincing language, some of the paths of the trackless winds of the mind, the high pressure areas and clouds and cold fronts of today's mental climate.

"It has become banal to say that this war is a revolution in men's thinking, in their way of living, all over the world. It is not banal to see that revolution taking place, and that is what I saw. It is exciting and a little frightening."

Mr. Willkie is excited, but he is not really frightened. He is willing to look the revolution in the face and find most of it good. Are we, his fellow citizens, equally honest and courageous?

The administrator of one of the country's largest hospitals recently stated in private conversation that, in his opinion, the period of "exploitation" of hospital employees is permanently over. "When the war is won or soon thereafter, a very large per cent of hospital employees will be unionized and will demand and receive pay and perquisites comparable to those then paid for similar work in industry," he declared.

In his opinion, hospitals can never again go back to the long hours and substandard pay scales that prevailed for so many years. Whether this results from the extension of regular trade unions into the hospital employee group or comes because professional organizations in the field assume a union type of activity is of little significance.

Another manifestation of the world-wide desire for democracy is the growing demand for broader recognition of all classes of society. In the heat of argument a critic of hospitals recently stated that "hospital trustees, with few exceptions, are plutocrats, Bourbons and reactionaries." To those who know many trustees, that statement is ridiculous. But it is true that relatively few hospital boards yet have representation from the clerical and labor groups of our society. And until we broaden our base of representation, we are susceptible to such cruel jibes.

Funds for the Future

HAVING mentioned on several occasions in these columns the wisdom of soliciting funds now for future hospital construction and modernization, we glow with pleasure to receive from Methodist Hos-

pital of Sioux City, Iowa, a handsome brochure on its school of nursing with a discussion of the plans for a new nurses' home and school. "Funds for the erection of this building are being sought now in order that construction may be started as soon as materials and labor are again available," states the brochure.

This far-sighted hospital will be ready to welcome the advent of peace in a practical way by adjusting its own educational program to the requirements of the new situation and by helping to cushion the nation's economy during the transition period.

Personnel Inventory

OTTO S. BEYER of the War Manpower Commission has suggested to employers that they initiate a "personnel inventory." While the inventory was suggested primarily to prepare for the drains that Selective Service will put on the personnel, there are important by-products.

The inventory should include a record of turnover for at least the last three or six months. This separation record should show occupation, date and cause of separation. Careful study of such a record will show where the greatest turnover is and may lead to the discovery of measures that can be taken to decrease it.

The inventory should include a list of occupations in which women are now employed and positions now filled by men that could be filled by women. In defining the suitability of occupations for women, Mr. Beyer urges that it be "in war terms and not in peace terms." The sole consideration should be whether it is possible to obtain women for such occupations and whether they will be able to "deliver the goods" once employed.

The inventory should also include a list of occupations in which a greater number of men with minor disabilities or older men can be employed, also where the employment of Negroes and other nonwhites can be increased.

Further, the inventory should include an analysis of the present training facilities and their maximum capacity. An estimate of the training time required for the principal jobs or classes of employment will be helpful. Mr. Beyer suggests finally that a list of key positions and at least a tentative list of understudies for each of these key positions should be made.

Such a study will facilitate making plans for recruitment and training of employees. While Mr. Beyer's remarks were not addressed to the hospital field, many of them apply to our problems.

In considering training programs, attention should be given to T.W.I. technics. A further article on this important subject appears in this issue. Reports reaching *The MODERN HOSPITAL* verify our earlier assertion that the use of these technics in actual training on the job speeds up training and makes it more effective and permanent. If you haven't heard of this program, read the Aird article in our December issue and the Dooley article presented this month (page 74).

WEAVING *the* PATTERN of the Postwar Hospital

THE matter of medical care is so integral a part of social security that we have in Great Britain the Beveridge report and here the recommendations of the National Resources Planning Board. Of the two, the Beveridge report is the more specific, because Great Britain has had a more extensive experience in so-called "socialized medicine" than we.

The Beveridge report presents what is essentially a scheme of unification "from which the anomalies and overlapping . . . which mark the British social services today have been replaced by coordination, simplicity and economy." It properly regards medical care not as a matter of charity but as a right. And so the report lays down the principle of a health service that "will ensure for every citizen whatever medical treatment he requires, domiciliary or institutional, general, specialist or consultant."

N.R.P.B. Report Is Not Specific

The National Resources Planning Board recommends "the development of adequate public health services and facilities in every county within the country" but does not clearly tell us how this is to be achieved. The Beveridge report, on the other hand, accepts the existing British system of health insurance. Our board wants "continued support from public and private agencies" but pays insufficient attention to the diminishing support that medical research and the hospitals are receiving from philanthropists because of high income and inheritance taxes.

To assure adequate medical and health care for everybody, federal appropriations are asked to aid states and localities in developing a system of regional and local hospitals and

WALDEMAR KAEMPFERT

Science Editor, New York Times

health centers and in properly distributing physicians, dentists, nurses and other medical aids. Plans must be formulated, we are told, that will enable the patient to budget expenses and to contribute to the cost of medical care according to his ability and to guarantee adequate compensation to physicians.

It is clear that the American report leaves the door wide open for experimentation, whereas the British report simply accepts and broadens existing medical services. In Great Britain the chief reliance is medical insurance. But the American report would permit taxation on large scale.

There is no reason to suppose that insurance, voluntary or compulsory, is the only way of meeting the expense of public medical care. Indeed, grave objections can be raised against any form of insurance and especially compulsory insurance. The method of payment is not nearly so important as are the quality of medical care, the fostering of research and the proper teaching of medicine and surgery.

There is no way of dodging taxation if we are to care for the families that must live in normal times on incomes of less than \$1000 a year. The American Medical Association admits as much. The ultimate tax bill can be kept down if we encourage citizens to form their own clinics for the scientific practice of medicine by competent groups of doctors. We want as little bureaucratic medicine as possible and that little should be limited to the publicly supported institutions to which the "medically indigent," as they are politely called, must resort.

We must weave into one fabric public research laboratories, medical schools, prepayment group clinics and hospitals and put them all under competent supervision to maintain

the highest standards. Possibly, there should be a secretary of health at the head of a well-organized department. But that secretary must not be dominated by the American Medical Association.

A supreme health authority, composed of leaders of medicine and selected, subject to Presidential approval, by the great medical schools, hospitals and research institutions, would be better. We shall not make much progress if a secretary of health is to receive his appointment in payment of a political obligation.

Research laboratories, medical schools and hospitals are occasionally massed in what we call medical centers. Whether it serves an agricultural region, a township, a thriving town of 50,000 or an industrial city like Pittsburgh a medical center should be the heart of a community's health activities and not the county medical society.

Work for Uniform Quality

Many small centers must become branches or affiliates of those in the large cities so that new knowledge will automatically saturate the whole fabric, with everywhere uniform quality of medical practice, teaching and medical research, and with the certainty that the ten year gap that now yawns between a major discovery and its introduction will be at least partially closed.

Medical care in these centers will have to be free for those who earn less than a statutory minimum. Those who can afford to pay must be charged fees that conform with a fixed schedule based on income. A millionaire will have to pay the top fee, but he will not be charged \$10,000, as he is now, for the removal of a tumor simply because he is a millionaire.

Not only will such a medical center serve to care for patients who come to it by bus or automobile, but its field doctors will rush to the farm

Abstracted from "Postwar Medicine and Hospitals," presented at the symposium on Civilian Hospitals in War Time, March 1943.

and the home when the call comes. So it will be in metropolitan areas.

Our magnificent municipal and voluntary hospitals are not yet closely woven into the pattern of medical practice, despite much free care, despite good ambulance service. They should be permitted to practice medicine in all departments and in the home and not merely in their out-

patient departments and their wards. And every hospital should be conducted not as a club that may be used only by a few privileged physicians but as a public service institution open to all physicians who are qualified. A doctor who is not fit to practice medicine in a reputable hospital is not fit to practice anywhere. Does all this spell what physicians

love to call "socialized medicine"? We use "socialized" education in this sense by establishing free schools and making truancy an offense, and this without abolishing private schools, colleges and universities. There is no reason why fine medicine cannot be practiced in public medical centers in competition with private physicians, hospitals and clinics.

The family doctor need not go the way of the dodo. Let the well-to-do seek him out, as they do now, and let them pay high fees for what they regard as personal attention. But the chances are that he will join a group of able colleagues, practice scientific medicine on the Mayo principle and make as much money, on the average, as he ever did.

Does this imply the abolition of the great voluntary hospitals? The Beveridge report makes no such recommendation, nor does our National Resources Planning Board. But we must recognize the fact that treatment in a hospital is no longer a privilege granted by charity but a right. Voluntary hospitals can and should work with publicly supported institutions. Rivalry will be good. It enables us to make comparisons.

Some of the voluntary hospitals, however, will have to go, partly because they are inadequately financed, partly because they are too small and too many. The voluntary and public hospitals should be unified into one system. And every voluntary hospital will have to justify its existence. It will have to do more research, and it will have to link itself with a medical school if it is not already so linked.

I think the day of the private practitioner is passing in the sense that his place will be taken in private practice largely by the hospital and the consultant and the specialist. So is the medieval conception of the physician's place in society. Even at this late day charity remains the chief form of medical relief, either outright charity or charity in the form of reduced fees.

Health is now a matter of national concern. It is like money in the bank. It is a national asset. The voluntary hospitals alone cannot solve the problem of national health. They should be preserved but they should also be interwoven into the new pattern of medical care demanded by new social necessities.

MUST *we* keep Records "INDEFINITELY"?

SISTER M. ADELE

Administrator, St. Francis Hospital, Pittsburgh

HAVE you ever known of a convention at which the question: "How long should medical records be kept?" has not been asked? How many times have you read it in hospital journals? And how well you know the answer: "Indefinitely." Most of us are definitely convinced that "indefinitely" is the definite answer.

I was convinced that this was the only answer to the question until a recent discussion with one of our senior physicians. We were speaking of our system of microfilming medical records when he asked: "How long do we keep medical records?" And I, glad that I knew the answer, said: "Indefinitely." "Indefinitely," he repeated as an inspiration seemed to flash across his brow. "And, why?"

I was glad I knew that answer also: For the benefit of the patient during his stay in the hospital and should he become ill in the future; for legal purposes—purposes too numerous to enumerate; for evaluating the work done by the medical staff individually and as a whole; for statistical purposes; for educational purposes, including research.

The senior physician heard me through and then picked some flaws in my arguments.

As to the statistical purposes and evaluation of the hospital's medical work, he pointed out, after these data are assembled the chart would have served its purpose.

Is the chart of value to the patient after the patient's death? Not only are charts of patients who have died in the hospital without personal value but those of patients who have died after leaving the hospital are valueless so far as the patient is concerned, said our staff man. For instance, if a man 80 years of age entered the hospital in 1908, he would now be about 115 years old and is probably dead.

There is no time fixed by law for keeping a patient's record, but could there not be enacted a statute of limitations as to the length of time hospitals would be required to keep such records?

As for research and education, could not a committee of physicians by sound statistical methods determine the number of charts that should be preserved for future study? For example, each hospital could keep a certain number of its pneumonia medical records or its diabetic records to be filed in the hospital or some central medical library organized in each city.

Doesn't it seem that a committee of physicians could formulate policies that would set time limits for the storage of medical records basing its conclusions on the value of the record to the patient, the law and medical research. You see, by this time I have come around to the same point of view held by that senior physician of ours.

WHY Windows?

LOUIS ALLEN ABRAMSON

Architect, New York City

MODERN engineering has developed artificial illuminants and mechanical ventilation to the extent that windows in surgical operating rooms have ceased to serve any useful function whatsoever, except, perhaps, psychologically.

Efficient ventilating systems even without air conditioning can provide not only sterilized filtered and tempered fresh air but fully automatic devices for the control of temperature, humidity, volume and velocity of air flow. Recent developments have demonstrated that air-borne particles as minute as 1/125,000 inch can be electrically removed.

The perfection of artificial illumination, too, has so advanced that natural light has long ceased to be essential, nor is it even desirable. It is not essential for it cannot produce intensities adequate for surgical procedures. It is objectionable because of inconstant intensity and coloration. And, being directional, it creates shadows when interrupted by the surgeon or attendant.

Unless it is supplemented by adequate artificial light, natural light causes obscuration, particularly in deep incisions. Frequently, it is the cause of ocular discomfort resulting from peripheral vision.

Yet, notwithstanding technological advancements, hospital designers, with relatively few exceptions, notably the Institute of Ophthalmology, Columbia-Presbyterian Medical Center and the White Memorial, Massachusetts General Hospital, still adhere to the obsolete operating room window, although it is true that, since the perfection of light diffusing and heat insulating glass, orientation has ceased to be important.

Hospital construction, except to serve the needs of the armed forces, has virtually ceased. However, nu-



Photograph by Myron Benson

Entirely dependent on both artificial illumination and air conditioning is this modern windowless operating room at Jewish Hospital, Cincinnati.

merous communities are now actively engaged in postwar thinking and planning. Why not then boldly abandon this adherence to obsolete forms and accept the advantages of mechanical and illuminating engineering skill? Furthermore, why not avail ourselves of this timely opportunity for an immediate scientific exploration to establish the yardsticks essential for adequate lighting design?

It is generally recognized that in planning the lighting for surgical procedures these criteria must be met: (a) adequate illumination of the operating field, (b) elimination of avoidable glare, (c) shadow reduction, (d) elimination of excessive heat, (e) color quality of the light and (f) protection against unexpected service failures.

As the form and dimensions of operating rooms vary with each institution and with functional requirements, no attempt will be made to prescribe the engineering design best adapted for a given installation. Individual preferences and prejudices for or against fixed or mobile, direct or indirect units must be recognized.

What is of vital importance at this time, however, is the determination of both proper intensity at the surgical plane and correct light coloration as the bases of adequate

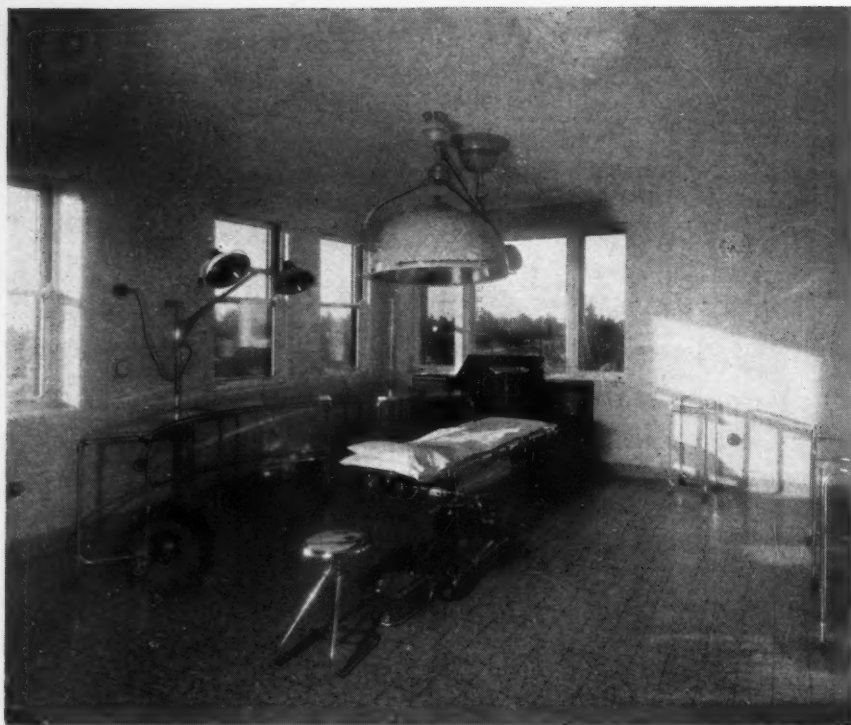
lighting design. Shadow and heat reduction, elimination of glare and multiple sources of electrical supply are problems of engineering skill and only relatively important.

Unfortunately, authorities have variously recommended light intensities at the surgical field of from 500 to 3000 foot-candles. Obviously, the great spread indicates the urgent need of further experimentation and clarification.

Too, the effect of color (and intensity) upon tissue has not been adequately explored. If it is correctly stated that diseased tissue is recognized not solely by texture and consistency but also by color, then the impact of light assumes equal importance. Color is an attribute of light and not, as often erroneously assumed, an inherent property of matter or substance.

Observe the changing effect of "daylight" fluorescent lighting upon foodstuffs or "daylight" mazda lighting upon fabrics. Obviously, then, tissue acquires changing appearance under varying lighting conditions and recognition by color may be made less rapid and precise. Conversely, recognition and evaluation could unquestionably be accelerated under proper illumination.

Tests conducted under actual working conditions were made of a



A room with a view, but aside from the esthetic satisfaction to the patient for the few minutes he is awake, the windows serve little purpose.

commercial luminaire employing standard fluorescent lamps of various colors. The use of "white" tubes resulted in an overintensification of red. So-called "daylight" tubes were substituted and red was paled out appreciably. The final test, consisting of a combination of both white and daylight, resulted in a reasonable fidelity of "color."

Recently, readings were taken in a metropolitan hospital. It was found that whereas in one room the intensity at the level of the operating table was 800 foot-candles with a colorimeter indication of "blue white," in the adjoining room the intensity was 1950 foot-candles with color of a definite "yellowish" cast. Incidentally, both rooms were illuminated by standard commercial operating fixtures.

It is to be hoped that through the combined efforts of illuminating engineering and medical societies, with the collaboration of lighting equipment manufacturers, quantitative and qualitative standards for intensity and coloration may be established and commercially adopted. The accruing advantages would be manifold.

A surgeon in any geographical area or even transferring his activities from one operating room to another within the same institution

could then operate with increased visual acuity and without the need of optical readjustment. Complete avoidance of unnecessary eye fatigue could be attained. It would be equally plausible to expect that speed of vision would be enhanced.

It may be pleaded that the omission of natural light would involve added burdens of capital investment and maintenance. True, a complete system of automatic mechanical ventilation would necessitate additional equipment and space allotment. The maintenance cost would be increased slightly. But will there not be commensurate compensation in increased comfort to and optimum efficiency for the surgical staff and the patient?

What of the possibility of mechanical failure? Efficient ventilating systems, without air conditioning, consist of complementary ductwork connected to (a) exhaust fan and (b) supply blower. The latter draws in fresh air, which after filtration or sterilization, or both, finally passes over heating coils for winter operation or, optionally, through a water spray or other cooling element during extremely warm weather.

Mechanical failure could occur only in either of the motor-operated fans. As good engineering practice provides motors with every conceivable protection against failure, it is

unreasonable to assume simultaneous breakdown of both units. However, in the event of motor failure or necessity for fan bearing replacement, the operating room could continue to function with reasonable comfort during the servicing interval with either the supply or exhaust operating singly.

If economic and other justification for the "inside" operating room is sought, these advantages merit consideration:

1. If the surgery is placed at grade level, contiguously with the accident entrance, the emergency operating room may be omitted.

2. If it is so placed, high-pressure steam mains for autoclaves and other sterilization are reduced to the minimum.

3. The recaptured upper story area, possibly including that of the laboratory and radiographic departments, may be planned for patient accommodation with better integrated nursing service and less noise.

4. Omission of operating room windows, screens and light regulating shutters will save funds.

5. As computations for heating radiation take into consideration heat losses resulting from air-infiltration and uninsulated exterior surfaces (glass), the heating load is reduced.

6. Possible reduction in the height of the operating room story may be achieved.

"Adequate lighting," whether or not supplemented by natural light, can and will be commercially available only if and when agencies equipped to furnish the criteria and those competent scientifically to determine and engineer the mediums of achievement join forces in a thorough rather than a casual collaborative effort.

Industry has reaped the reward of similar collaboration, and whereas until quite recently its lighting designs were predicated upon but one primary consideration, namely, intensity, illuminating engineers now recognize physical factors, such as fatigue, visual acuity and speed of vision, in relation to light intensity and color composition and their effect upon speed of production.

Certainly, no other "seeing" imposes a greater visual task than does that demanded of the surgeon. Possibly in no other field has there been less acceptance of the fruits of scientific endeavor.

Volunteer Service Will Fail—

*without the cooperation
of the professional staff*

FIRST consideration in inaugurating volunteer service in any hospital should be given to selling the idea to the professional staff. All members of the hospital organization should be informed which departments will receive the first volunteers and about the relationship of the service to their own department.

Duties in the assigned stations should be definitely outlined. It would be prudent to emphasize the fact that the volunteer is not supplanting the salaried worker but by contributing supplementary assistance is releasing that person for technical tasks.

It should be impressed upon the staff that the volunteer is not offering her services out of a personal necessity but because of an inherent community interest and a Christian desire to help her neighbor. The enthusiasm that has inspired her to apply for volunteer work cannot help but contribute toward making her undertaking a successful one. But she must have the cooperation and evident appreciation of her department. Her efforts become rather sad if she is not welcomed and made to feel an important and necessary part of the organization. The only compensation she desires is appreciation for a job well done and her implied inclusion as an intelligent and needed member of her department.

Decide on Work to Be Done

Discipline should not be a problem if both the hospital personnel and the volunteers are adequately and sufficiently prepared and trained in their duties and their relationships to one another. It is up to the supervisor of volunteers to consult with the department head before initiation of the service in that unit is announced to the rest of the personnel and to consider with that person the definite duties and responsibilities of the voluntary worker.

Typed detailed instructions of each routine procedure for which the aide is held accountable should be attached to a manuscript backer and kept in a place in the department at

which they will be accessible and can be read by everyone. The volunteer should be instructed to reread the manuscript each day as soon as she reports on duty for the first four or five weeks and to consult it after that time when she is in doubt about any procedures.

The station supervisor also must be impressed with the importance of familiarizing herself thoroughly with the details of the manuscript.

During the first interview the supervisor of volunteers should strongly emphasize the great importance of a high standard of ethics and discipline in a hospital. The aide should be told that a volunteer group maintains the confidence of the hospital's professional and administrative staffs because efficient and faithful charter members of the organization have convinced them of the merit and future possibilities of such supplementary service. For this reason it is one of her most important obligations to see that the standards are never lowered in the slightest degree. Inability to conform leaves no alternative but dismissal.

A volunteer manual is almost a necessity as it functions as a protective agent to both hospital and volunteer. When the new volunteer has been interviewed and accepted by the supervisor it would be well for the latter to read and explain the rules on ethics, appearance, conduct and attendance and the reasons why strict observance of them is so necessary. Later, in the event of infraction of the rules, there can be no question as to lack of proper instruction as a reason for inefficiency.

KATHRYN S. WALSH

Supervisor of Volunteer Services
University of Michigan Hospital
Ann Arbor, Mich.

It would be well to devote at least the first page of the manual to a short history of the hospital and other pertinent information as to its administrative policies and position in relation to the community or the state.

Other items of interest to the lay person might include the bed capacity; the average yearly clinic census; the approximate number of doctors and nurses functioning on the active staff; data about the amounts of materials and supplies used in a day or month, and a paragraph describing the recreational projects for both adult and adolescent patients.

Rules for a Good Volunteer

The first rule should be a repetition of the admonition stressed in the initial interview, *i.e.* that the volunteer must preserve the high set of standards established by those who initiated the service. Other rules that might easily be applied to volunteers in any hospital set-up would include some of the following:

1. Always consider yourself bound by the same rules and regulations as the professional worker.

To a stranger the volunteer is as representative of the spirit of the institution as is the professional agent.

2. You will learn many things of a highly confidential nature that must never be repeated outside the hospital or even be discussed with anyone within the institution. The result of such indiscretion is often unfair criticism and misinterpretation of the good the hospital is doing. Forget the name of every patient when you leave the building.

The volunteer should be warned at the time of her first interview that any breach of this rule would mean instant and unconditional dismissal.

3. Never repeat a diagnosis or allow any person not professionally and directly concerned with the patient to read any record.

The volunteer should understand that this rule also applies to herself. A patient's medical record is a confidential document and there is no necessity for any person other than the doctor, the nurse or the record clerk to examine it. The volunteer should be instructed about the institution's policy relative to opening a record to any doctor outside the hospital's staff or to legal representatives of the patient or his insurance company.

4. Report to the supervisor of volunteers any criticism of the hospital heard while on duty. Do not discuss it with any other members of the personnel. Constructive criticism is always appreciated.

Let this serve as a hint to the aide not to let herself become involved in interdepartmental differences or to discuss them with any of the other workers but to bring such matters to her supervisor for clarification.

5. Learn the names of the personnel in your department and always maintain a strictly professional attitude regardless of how well you may be acquainted outside the hospital.

The indiscriminate use of first names and a corresponding attitude of casual levity among those of the personnel who are in contact with the public most certainly detract from the dignity and the essence of hospital service.

6. Never discuss prices. These matters are handled entirely by the credit department.

Some hospitals base fees upon a financial classification of the patient's ability to pay; therefore, the prices of examinations and tests cannot be uniform. Any person who quotes an incorrect fee to a patient is encouraging misjudgment and misinterpretation of the hospital's administrative staff.

7. Since voluntary work is always supplementary in nature there is no promise of a salaried position in the hospital at the conclusion of the service.

It should be clearly understood by the applicant that the hospital is in no way obligated to give her preference should she be using volunteer service as a means of access to a salaried position.

8. Try to make yours the most

interesting and important of all services. If you tire of what you are doing notify the supervisor of volunteers and she will place you in another department.

It is better to rotate a volunteer on different services if there is any evidence of disinterest in her assignment than to have her drop the whole project with some evasive excuse.

9. Your uniform has been chosen for its color and suitability to the task which you have to perform. Remember that the dignity of your uniform and the spirit of the service which you have volunteered to give are not carefully preserved if you do not strictly conform to the rules for appearance.

10. So that you will receive full credit for the time you have given to the hospital be sure to sign in and out in the volunteers' register each day you are on duty.

A time book with spaces indicating name, time on, time off, total number of hours on duty that day and station should be kept in the volunteer office. At the end of the month a report should be sent to the director of the hospital stating the total number of hours of volunteer service given during that month; the names of new volunteers and the services to which they have been assigned; the names of persons who have resigned and the reasons; service awards and descriptions of new projects submitted for approval.

Volunteers are always grateful for some recognition of the time they have given and most zealously anticipate the awarding of stripes, stars or other insignia indicating the completion of a set number of hours.

11. New volunteers will receive specific instruction in their particular duties from the director of volunteers or from some member of the service appointed by her.

By appointing as a senior volunteer or captain one girl who has served reliably in a particular department, some of the responsibility of training the recruit can be removed from the shoulders of the professional employee. The new volunteer should report at least once or twice for training on the day of the senior volunteer's assignment; from then on, she should be responsible to and take instruction from a particular professional person in the clinic or department.

12. If you cannot find a card, record or a report on a patient or if you have never heard the name of the doctor the patient is asking for, do not let the patient know this. He is bound to be upset and gain the wrong impression from a trivial incident.

13. Volunteers, while on duty, are requested not to visit friends who are in the hospital. Also, do not call on them until you have learned of their admission through the family or friends outside the hospital.

Again we remind the volunteer of the necessity of strict suppression of all information about patients even to the point of not disclosing to the family her knowledge of the current hospitalization.

14. By your very acceptance of volunteer service you have signified your willingness to serve. We rely upon you and expect you to be present on the days you have indicated. If illness or any emergency necessitates your absence, you are expected to arrange for a substitute from one of the members of your group. Your station in the hospital must be covered at all times.

By having a short meeting of all the volunteers in a department about once every six weeks the new volunteers will have an opportunity to meet the older ones. Then, when illness or any emergency arises, it will be easier for them to arrange for a substitute and thus ensure an uninterrupted schedule. The captain should be notified of the exchange as soon as possible.

Should a volunteer be absent more than twice without notification she will be dropped from the service. Too many absences would indicate a lack of interest on the part of the aide and would seriously impair the standing of the volunteer service.

A hospital is no place for irresponsible or lax people. For the protection of those who are faithful and industrious one cannot tolerate conduct that would reflect upon their integrity. We find that the volunteers themselves are the ones who are the most insistent on and appreciative of the strict enforcement of this rule.

Rules on smoking, personal telephone calls, the institution's policy as to medical service rendered to the volunteer workers and official visiting hours should also be noted in the manual.

While working in the hospital the volunteer head must have undisputed authority over her aides in assigning the projects they prefer, judging the quality of the performance and exercising any disciplinary action necessary to ensure the continuation of efficiency and tactful contact with patients and personnel.

The disciplinary problem of any group of individuals will always present a number of so-called "head-aches," but they can be kept to a minimum by strict observance of ethics by all factions involved, both volunteer and professional.

The success of the venture is just as much up to the incumbent staff

—and, at the first, probably more so—as it is to the timid novice. A few well-chosen and resourceful volunteers to start the active service will do more to sell the idea to any skeptical staff members than will too large a group of persons with whom the supervisor of volunteers is not well acquainted.

Facts and Figures on the WAGE WITHHOLDING TAX

UNDER the new tax law just passed by Congress, every employer is required to deduct and withhold taxes on wages and salaries paid to his employees on or after July 1, 1943, for a pay roll period beginning on or after that date. The amount to be withheld is the greater of the following:

1. Twenty per cent of the excess of each payment of wages over the "family status withholding exemption"; or

2. Three per cent of the excess of each such payment over the "Victory tax withholding exemption."

Probably most hospitals will adopt the simplified method of computing the amount to be withheld, which is discussed later and is illustrated in the table on page 62.

In determining the amount to be withheld, the employer may compute the wages to the nearest dollar. The "family status withholding exemption" for a single person is \$12 per week; \$26 semimonthly, or \$624 per year (also it may be computed at \$1.70 per day). Twice these sums are allowed for a married person claiming the whole exemption, plus \$6 per week or \$13 semimonthly or \$312 annually for each dependent other than the first. The "Victory tax withholding exemption" is the same as the exemption for a single person as given above. It has no relation to the family status of the taxpayer.

When wages are paid for an ir-

regular period (*i.e.* not weekly, bi-weekly, semimonthly or monthly) the daily or miscellaneous period is used. The family status withholding exemption in this case is \$1.70 for a single person, \$3.40 for a man and wife and \$0.85 for each additional dependent. If a person is paid every 10 days, the family status withholding exemption is the daily exemption multiplied by the number of calendar days in the period.

Payments made after July 1, 1943, for a pay roll period starting prior to that date (a period subject to the old 5 per cent Victory tax deduction and not to the new 20 per cent withholding provision) should be separated from wages paid after July 1 for pay roll periods beginning after that date.

Each employee must file Form W-4 with his employer so that the latter can determine the family status exemption. This form shows whether he is married and living with spouse, the number of his dependents and whether he is claiming all, part or none of the family status exemption. If no certificate of exemption is furnished, the employer withholds on the gross wages without any deduction. If the family status changes, the employee must file a new certificate within ten days of the change.

If a certificate is filed after the commencement of employment because of a change of status, the employer need not put the change into effect until the first payment of wages made after the first "status determination date" occurring at

least thirty days after the certificate is furnished the employer.

Status determination dates are January 1 and July 1 of each year. This gives the employer time to adjust his records. However, the employer may make the change effective earlier if it is feasible to do so.

A much simpler procedure for the employer than following the various exemption tables is to use the wage bracket tables that have been approved. One such table, that for semimonthly wage payments, is reproduced here. Other tables are available on weekly, bi-weekly, monthly and daily or miscellaneous periods.

Employer-employee relationship under this act is determined as it was under the Victory tax.

Employers file returns and pay taxes withheld in the same manner as returns are filed and taxes are paid under the Social Security Act. It is expected, however, because of the large sums involved that employers in the future may be required to remit monthly instead of quarterly.

Receipts must be furnished by employers to employees on or before January 31 of the year following that in which the tax is paid. When an employee leaves, his receipt must be given him on the last day that wages are paid to him. The Commissioner of Internal Revenue may grant employers a thirty day extension of this time. Duplicate receipts filed with the collector relieve the employer of the duty of filing information returns on Form 1099.

Based on material prepared and released to The MODERN HOSPITAL by the Research Institute of America, New York City.

Semimonthly Wage Bracket Withholding (Simplified Computation Method)

If the pay roll period with respect to an employee is semimonthly

And, (1) such person is a married person claiming none of personal exemption for withholding and has—

And the wages are

No depend- One depend- Two depend- Three depend- Four depend- Five depend- Six depend- Seven depend- Eight depend- Nine depend-
ents ent- ents- ents- ents- ents- ents- ents- ents- ents- ents

Or, (2) such person is a married person claiming half of personal exemption for withholding and has—

No depend- One depend- Two depend- Three depend- Four depend- Five depend- Six depend- Seven depend-
ents ent- ents- ents- ents- ents- ents- ents- ents

Or, (3) such person is a single person and has—

No depend- One depend- Two depend- Three depend- Four depend- Five depend- Six depend- Seven depend-
ents ent- ents- ents- ents- ents- ents- ents- ents

Or, (4) such person is a married person claiming all of personal exemption for withholding and has—

No depend- One depend- Two depend- Three depend- Four depend- Five depend-
ents ent- ents- ents- ents- ents- ents

Or, (5) such person is head of a family and has—

No depend- Two depend- Three depend- Four depend- Five depend- Six depend-
ents or one depend- ents- ents- ents- ents- ents-
dependent

At least But less than

The amount of tax to be withheld shall be—

\$0	20	\$2.00	.....	.....	.....	.....	.....	.....	.....	.....	.....
20	30	5.00	\$2.40	.....	.....	.....	.....	.....	.....	.....	.....
30	40	7.00	4.40	\$1.80	\$0.30	\$0.30	\$0.30	\$0.30	\$0.30	\$0.30	\$0.30
40	50	9.00	6.40	3.80	1.20	.60	.60	.60	.60	.60	.60
50	60	11.00	8.40	5.80	3.20	.90	.90	.90	.90	.90	.90
60	80	14.00	11.40	8.80	6.20	3.60	1.30	1.30	1.30	1.30	1.30
80	100	18.00	15.40	12.80	10.20	7.60	5.00	2.40	1.90	1.90	1.90
100	120	22.00	19.40	16.80	14.20	11.60	9.00	6.40	3.80	2.50	2.50
120	140	26.00	23.40	20.80	18.20	15.60	13.00	10.40	7.80	5.20	3.10
140	160	30.00	27.40	24.80	22.20	19.60	17.00	14.40	11.80	9.20	6.60
160	180	34.00	31.40	28.80	26.20	23.60	21.00	18.40	15.80	13.20	10.60
180	200	38.00	35.40	32.80	30.20	27.60	25.00	22.40	19.80	17.20	14.60
200	220	42.00	39.40	36.80	34.20	31.60	29.00	26.40	23.80	21.20	18.60
220	240	46.00	43.40	40.80	38.20	35.60	33.00	30.40	27.80	25.20	22.60
240	260	50.00	47.40	44.80	42.20	39.60	37.00	34.40	31.80	29.20	26.60
260	280	54.00	51.40	48.80	46.20	43.60	41.00	38.40	35.80	33.20	30.60
280	300	58.00	55.40	52.80	50.20	47.60	45.00	42.40	39.80	37.20	34.60
300	320	62.00	59.40	56.80	54.20	51.60	49.00	46.40	43.80	41.20	38.60
320	340	66.00	63.40	60.80	58.20	55.60	53.00	50.40	47.80	45.20	42.60
340	360	70.00	67.40	64.80	62.20	59.60	57.00	54.40	51.80	49.20	46.60
360	380	74.00	71.40	68.80	66.20	63.60	61.00	58.40	55.80	53.20	50.60
380	400	78.00	75.40	72.80	70.20	67.60	65.00	62.40	59.80	57.20	54.60

\$400 or over

20% of the excess over \$400 plus

\$80.00 \$77.40 \$74.80 \$72.20 \$69.60 \$67.00 \$64.40 \$61.80 \$59.20 \$56.60

If the number of dependents is in excess of the largest number of dependents shown, the amount of tax to be withheld shall be that applicable in the case of the largest number of dependents shown reduced by \$2.60 for each dependent over the largest number shown, except that in no event shall the amount to be withheld be less than 3 per centum of the excess of the median wage in the bracket in which the wages fall (or if the wages paid are \$400 or over, of the excess of the wages) over \$26, computed, in case such amount is not a multiple of \$0.10 to the nearest multiple of \$0.10.

Refunds or credits of overpayments will be made to employers only to the extent that the amount was not deducted by the employer from the employee's wages.

Any amount withheld in excess of the tax imposed on the employee is an overpayment. Any overpayment (after allowance of credits for taxes withheld at source or current credits against the Victory tax) may be credited against the estimated tax for any subsequent taxable year.

The withholding provisions of the Victory tax expire on June 30, although the tax itself remains in effect until the last day of the tax year in which the war ends.

Since the withholding provisions will not place on a current basis those persons who are receiving dividends or wage earners whose tax exceeds the 20 per cent withholding rate, their tax must be estimated and paid in quarterly installments.

Physicians in private practice and other persons whose tax will not be paid (or will be paid only in part) through the withholding arrangements must estimate their incomes and pay the tax in quarterly installments.

Persons who must make a declaration showing their estimated tax for the taxable year include: (a) single or married persons not living with their spouses, if their gross income from wages exceeds \$2700 in the current taxable year or did in the preceding year; (b) married persons whose combined income from wages exceeds \$3500 in this taxable year or the preceding one; (c) single or married individuals whose income from sources other than wages is expected to exceed \$100 and whose gross income is enough to require an income or Victory tax return to be filed or was enough in the preceding tax year, and single or married people who had to file a return in 1942 but who expect smaller wages in 1943.

For 1943 the declaration must be filed with the Collector of Internal Revenue on or before Sept. 15, 1943.

This declaration may be amended or revised on or before the fifteenth day of the last month of any quarter of the taxable year. Thus a taxpayer using the calendar year could revise his declaration until December 15, if there was no previous amendment to the declaration in the previous quarter.

More Space for War Workers at South Chicago Community Hospital

CLARA SCHAFER, R.N.
Superintendent
ELMER C. CARLSON
Architect

CONSTRUCTION DETAILS

GENERAL DATA: Five story addition to South Chicago Community Hospital, bringing total capacity of hospital to 150 beds. Completed in 1942.

CONSTRUCTION: Steel frame and open web bar joists. Exterior, light face brick with cut stone and glass brick trim.

FLOORS: Lobby, operating rooms, first floor corridors, pea gravel terrazzo; other corridors, asphalt tile; patients' rooms, linoleum.

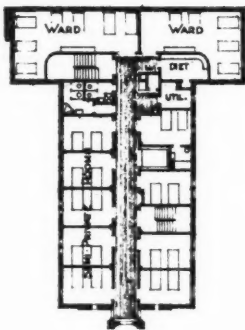
WALLS: Operating rooms, tile.

INTERCOMMUNICATING SYSTEMS: Silent nurses' call, all beds to nurses' stations; doctors' call and doctors' in-and-out register.

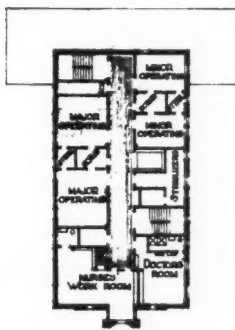
ELEVATORS: One passenger elevator to fifth floor. Dumb-waiter from kitchen to diet kitchens on each of three floors.

VENTILATION: All inside rooms, mechanical ventilation. Operating rooms, air conditioned.

COSTS: Building without equipment, \$250,000. Cost per cubic foot, 60 cents.



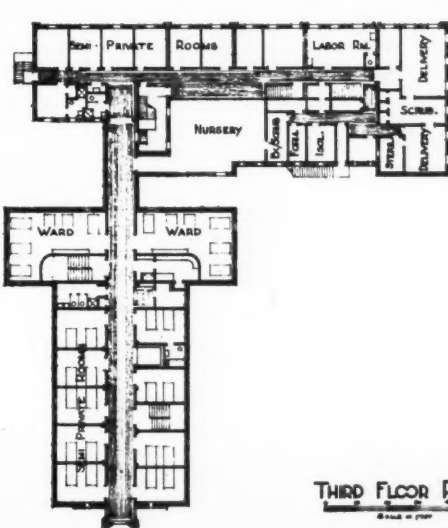
FOURTH FLOOR PLAN



FIFTH FLOOR PLAN



SECOND FLOOR PLAN



THIRD FLOOR PLAN

Above: Architect's drawing of new addition. Left: The plans of the second and third floors show the enclosed bridges between the old and new buildings. The entire third floor is devoted to the obstetrical department, the new building housing patients' rooms and wards while the old section was remodeled to provide labor and delivery rooms and the nursery. The ground floor of the new building (not shown) houses administrative offices, x-ray department, laboratories and kitchen.

We Can Keep Our Hospitals

VOLUNTARY

THERE is little in the trends of federal government philosophy and action during the last decade to justify a belief that in the future many areas of our national affairs may not be increasingly under even stronger centralized control.

Whatever shading of political faith colors the administrations in Washington during the postwar years, it is highly unlikely that in matters that affect the lives and health and education of the vast majority of Americans there will be a reversion to the rugged individualism that characterized our national attitude prior to 1933.

Symptomatic of this trend is the move to bring universal hospitalization under social security with a levy upon wage earner and employer to provide hospital care. After several years' discussion, this issue is again before Congress in the Wagner-Dingell Bill. The proposal has the active support of C.I.O. and A.F. of L. union leaders.

Too Many Without Insurance

Certainly, the situation that brought it into prominence has not materially changed despite the tremendous increase in national income, particularly at the semiskilled and skilled labor levels. Even the increases in Blue Cross membership have not sufficiently reduced the number of Americans who are without adequate provision for proper hospitalization.

If hospitalization under social security does in fact imply a menace to the voluntary hospital it can be neither ignored nor shouted down.

The cause of the voluntary hospital will not be served by any attempt to stem the tide of public opinion in favor of fuller acceptance by the federal government of its responsibilities. The salvation of voluntary hospitals would seem to lie in the

**RUSSELL T. SANFORD
and ALDEN B. MILLS**

direction of cooperation and guidance rather than in an attitude of obstruction and resistance to a force that may before long be so large as to engulf them.

The voluntary hospital may be said to have passed in the last three decades through a primary phase of its development. From chaos and individual inadequacy, hospitals have arrived at a point where their organization, standardization and efficiency are widely recognized. Generally speaking, they are individually adequate within their spheres of service or are on the road to competence of their own impetus.

The next phase of their development must be along the lines of geographic and economic adequacy. The A.M.A. hospital census reports that at the end of 1942 there were 2926 nonprofit hospitals with a total of 316,291 beds, serving 7,463,648 bed patients, or about 60 per cent of the total. Yet 89,000,000 Americans live in states with fewer than 4.5 general hospital beds per thousand of population (including governmental, proprietary and voluntary hospital beds).

It is irrelevant that the optimum may be somewhere below or above this figure of 4.5; the fact is that more than half the population is not adequately served by available general hospital facilities. It is equally irrelevant to the sick person 50 miles from a hospital that it and 2988 hospitals somewhere else are approved by the American College of Surgeons and that hundreds of others meet the A.M.A. standards.

Side by side with the matter of geographical distribution of hospital facilities stands the matter of the costs of hospitalization. Here again the comparative is less important

than the absolute. Hospital efficiency has been increased with commendable intelligence and diligence.

Unquestionably, hospitals today render more service per dollar, in relation to cost of living, than they did a decade and more ago. This achievement, however, means little to the patient who might afford a dollar or two per day yet finds himself confronted with accommodations at a minimum cost of \$4 a day. Further possible reductions in costs may still leave charges too high to afford decent hospital service for all the people.

Everyone Is Concerned

These two matters of geographic distribution and hospitalization within the means of all who need it are concerns of all the people. They have a direct bearing on the health of the nation and hence upon the welfare of the nation. Thus, responsibility lies squarely with federal government if our whole concept of democratic government is to endure and if ours is to be truly a government not only by the people but for the people.

Here, however, a vital distinction must be drawn between federal *responsibility* for any department of national welfare and federal *operation* of the agencies to achieve it. The distinction is clear in the provision, on the one hand, for federal bank deposit insurance (in which the government accepts responsibility for the security of bank accounts without going into the banking business), and the provision for social security on the other. In the latter instance government went into the annuity insurance business because no feasible means of accomplishing the same end had been worked out by private enterprise.

"The Lord helps those who help themselves." In essence this seems

★ *It is indigent people and communities of low income that are in need of continuing subsidies, not the hospitals*

to be, broadly, the goal of federal government, too. If the disposition of Washington is merely to assume responsibility and insist that all the people be served as far as possible by voluntary and community enterprise and to subsidize this enterprise without exercising control, it may be expected that the voluntary hospital can escape stifling encroachment of government to the extent that it is able to serve. Demonstrated ability to accomplish the demanded end may earn the right to exercise continued autonomy as to means.

How, then, can the voluntary hospitals help themselves? How can they bring about optimal distribution and adequate service within the ability of all the people to pay? Obviously, the first step is to determine the need. The first function of the National Commission on Hospital Service may well be to explore distribution of hospital facilities, with an analysis of private, semiprivate and ward facilities in relation to total capacity, over-all adequacy of facilities and the income level of the area served. This much would be only an extension of the present A.M.A. census. The commission could also study areas in which new hospitals or additional beds are needed.

With such diagnostic data in hand, the commission would be in an excellent position to undertake the needed therapy, without which any study would be but a mass of interesting figures more than likely to suggest to federal government the need for intervention. The steps that could be taken might be as follows:

1. The commission should obviously encourage the establishment of new hospitals with local subscriptions plus federal aid from such funds as those made available under the Lanham Act and similar federal legislation. Existing religious and community organizations should be urged and helped to undertake these new responsibilities.

2. The commission could enlist the support of strong existing hospitals, medical schools and religious and other groups, which could be persuaded to lend their assistance in the establishment of coordinated and interdependent groups of hospitals. Such an effort might well follow and expand the pattern now being advanced in New England by the Bingham Associates Fund and in Michigan by the Kellogg Foundation. Centralized equipment and service could be put at the disposal of hospitals too small to justify the possession of their own.

Such a plan has ample precedent in the branch banking followed in many states, where strong institutions extend their facilities to assure security to smaller institutions that need the strength of centralized resources. Applied to the hospital field, this method would assist the integration of small groups into a national hospital network, cutting across geographical and political boundaries and really serving all the people. Quite possibly this plan would reduce hospital costs and not only would increase hospital efficiency but would ultimately achieve the goal of universally available hospital service of good quality.

With this evidence that the voluntary hospitals of America were facing their responsibility, they could solicit federal aid without incurring the risk of federal domination and sacrifice of their cherished and useful autonomy.

3. To assist those in the income level where even such hospital service on a prepaid basis would be beyond their means, the federal government might well extend similar aid to Blue Cross plans.

In most communities that can support voluntary hospitals, these institutions have demonstrated their ability to serve well and manage their fiscal affairs on a community basis without appeal to any governmental

agency. This should convince the federal government that it is indigent people and communities of low income that need subsidy, not the hospitals. Federal aid should be solicited on that basis.

Federal government has no more reason to control hospitals than it has to control the food industry. When people can't afford enough food for sustenance, federal government has subsidized the needy individual, not the corner grocer. The same general policy should be applied to hospitals. There is no reason to suppose that it will not be applied if hospitals themselves undertake the job of correcting distribution of hospital service so that it will be at least as efficiently distributed as other commodities.

4. Having aided the indigent to obtain the benefit of Blue Cross plans, the federal government could further fulfill its responsibility if it required that all employed persons, as a condition of employment, must provide themselves with at least a minimum amount of hospitalization insurance. Thus, the government would assume responsibility but would leave implementation in voluntary or private hands.

Although this proposal is new and may appear revolutionary it has ample precedent in the compulsory automobile liability insurance law of Massachusetts and in the workmen's compensation laws of most states. The problems encountered, although complex, would not baffle American ingenuity.

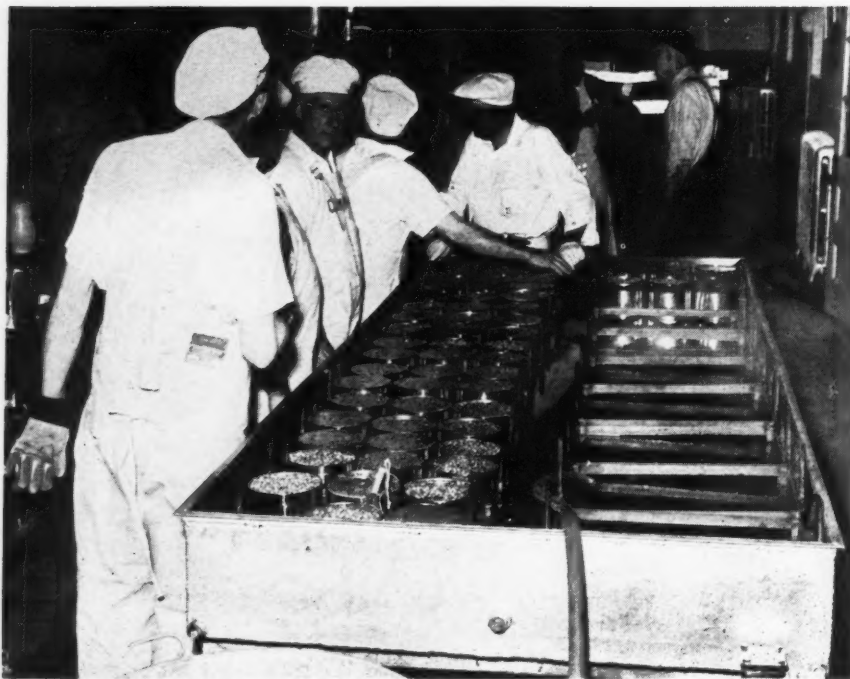
5. A further impetus to Blue Cross plans could be made easily if Congress would authorize pay roll deductions for governmental employees for this purpose. Doubtless, many other specific means of cooperation could be found that would discharge the obligations of a people's government to the people without destroying the individual and collective autonomy of the voluntary hospital.

Colorado State Hospital works for SELF-SUFFICIENCY *to speed the day of victory*

RALPH C. TAYLOR
Pueblo, Colo.



NAVAJO RUG WOVEN FROM COTTON HOSE



PEAS ARE BOILED IN GALLON CANS

DECLARING war on war, the Colorado State Hospital at Pueblo has been mobilized to help speed victory by being as self-sufficient as possible.

By converting all available manpower among its patients into maintenance activities, the hospital is able to get along with fewer employees and to permit more of them to go into the armed forces and war industries. By utilizing every bit of waste and by the application of ingenuity, the institution needs less of the things that are vital to the nation's war needs.

Obviously, these things did not come about overnight; they have been developing for the last decade under the management of Dr. F. H. Zimmerman, superintendent, who believes that the economical administration of an \$8,000,000 institution maintained by taxes demands keen business practices.

Keeping patients busy in wholesome work that helps maintain the institution not only is a move toward economy but is occupational therapy of the highest type. Hundreds of patients find their way back to society through a combination of medical treatment and occupational therapy.

This institution has concentrated on producing as much of its own food as possible. This not only ensures ample food but means best quality, which would not be possible if everything had to be purchased under the hospital's restricted budget on the open market.

Vast quantities of vegetables are grown on fertile river-bottom lands owned or leased by the hospital. Patients tend and harvest the garden crops. This provides an abundant flow of fresh vegetables in season. Surplus root vegetables are pitted or put in cellars for winter consumption.

These vegetables and fruits purchased from Colorado farmers are put up in the hospital's canning factory. Last season 100,000 gallons of foodstuffs were canned, many of them products that cannot be purchased at any price in the quantities the hospital needs.

Off-season vegetables needed for special diets are grown in greenhouses which also furnish an abundance of flowers to brighten the wards.

The hospital has its own Holstein dairy herd that produces 2,200,000 quarts of milk a year, all of which is pasteurized, homogenized and delivered in bottles to the hospital. This guarantees a supply of pure milk that does not have to be rationed. A poultry farm furnishes 2,400,000 eggs a year.

A piggery serves the double purpose of providing an outlet for kitchen scraps and furnishing part of the pork consumed at the hospital. The turkey ranch produces 1000 turkeys, enough for the Thanksgiving and Christmas dinners, a delicacy that would otherwise be impossible for the institution.

Figured at market prices, and after deducting for all costs, the gardens, dairy, poultry farm, piggery, turkey farm and canning factory saved the hospital approximately \$135,000 last year.

Modern equipment is used in a score of kitchens to prepare mass meals as tastily as possible and with economy in mind. The hospital has its own butcher shop. Although it does no slaughtering, the hospital handles all its meats, including refrigeration and cutting.

There is a bakery at the hospital in which all bread, cakes, cookies and pastries are turned out economically. Here, again, patients benefit from the work.

Almost all of the serving of food is done in cafeterias, except on wards where patients are unable to serve themselves. This hospital was one of the first mental disease institutions in the country to use cafeterias. It was found that mental strains were eased and more of the homey atmosphere was injected when patients could select their own foods. By choosing what they want and in the quantities they desire, there is practically no waste food, which was found to be a tremendous item.

A huge laundry keeps the hospi-

Gardening, canning and weaving are some of the contributions made by patients to the winning of the war



PATIENTS TEND THE VEGETABLE GARDEN

tal's linens from swamping already burdened commercial downtown plants.

To cooperate in the conservation of rubber and gasoline, the hospital is returning to the use of horses and wagons. More land has been leased to grow feed for horses. Tractors and trucks used on grounds and farms are being replaced by teams in many instances and this summer horses will pull the lawn mowers.

Seemingly nothing ever is thrown away at the hospital. Articles that are removed from construction and equipment are used again in the carpenter, machine, pipe, electric and paint shops.

Apparel, linens and similar items are mended as long as possible but they are never thrown away. When no longer fitted for the purpose for which it was intended, the article is condemned and sent to the occupational therapy department, where men and women patients find new ways to convert it into something else for the maintenance of the hospital.

Patients frequently manifest unusual ingenuity in inventing new

uses for old things. Wornout dresses are made into colorful quilts and into rugs woven on looms. Men's hose with heels and toes worn away are made into mittens. Pockets from men's discarded trousers make good bedroom slippers with a bit of sewing. Scraps from screening are made into fly swatters. Broken bowling pins become bookends when cut in two and polished. Old hardwood trees that fall on the grounds are worked up into furniture and croquet sets. Women's hosiery is ideal for woven rugs.

Salvaged cans, metal, rubber and tires go into the community salvage pile.

Even spent steam returning from heating lines is not wasted. Some of it operates motors that are replacing gasoline engines; some of it generates electricity.

Not content with these contributions that are helping reduce the hospital's demands upon the nation's vital war needs and keeping taxes as low as possible, the patients and employees are buying war bonds, sewing for the Red Cross and doing a multitude of jobs to help win the war.

Not QUANTITY but QUALITY

counts in personnel administration

THE first step toward efficient hospital organization is the establishment of a personnel department. The extent of the personnel program and the type of hospital being considered are important factors in deciding whether a full-time or part-time personnel officer is to be employed. Generally, a full-time officer is needed if the staff exceeds 400; otherwise a part-time officer can be effectively used.

A personnel program must be developed and planned to suit the needs of the institution and a thorough study must be made of every job. The hit-and-miss method of employment is a thing of the past and has no place in the modern hospital.

Department Head Has Key Post

One of the key positions in a hospital is that of department head. It is frequently the custom to choose an intelligent and dependable worker from within the department and promote him to head position as a fitting reward for loyal service. Administration of departmental functions is quite a different job from that of being a good worker; consequently, he must be trained for the task of supervising the personnel under him or the department will suffer from inefficiency and poor direction.

The qualities of a good department head are diplomacy, consideration, patience and an understanding of human nature. To these, add a complete knowledge of the department's functions and you will have not only a good department head but a contented staff. It is also the task of the department head to introduce the new employe to his job and to provide for his continuous supervision and guidance, to establish an efficient routine and to set a standard of work that can be maintained.

CLYDE F. DIDDLE

Permanente Foundation Hospital
Oakland, Calif.

In place of the customary administrative get-together the personnel officer or the administrator should arrange a series of "administrative conferences" for the development of efficient department heads. These conferences, to be held during working hours, should be carefully planned educational programs designed to increase the interest of each member in the proper conduct of his department. Individual papers on assigned or selected subjects should be prepared by members and presented to the conference.

The person in charge of the program should so plan his administrative conferences that each meeting develops a definite point of training. A pedagogic attitude should be avoided and an atmosphere of informality encouraged.

Each member should be allowed to choose his own subject from a prepared list of pertinent topics. Plenty of reference material should be available so that a preliminary study of the subject may be made. Advance study and preparation not only achieve worth-while results but create a feeling of authority in the speaker that bears fruit in his work as a department head. Many subjects are suitable for discussion at these conferences, such as the following: responsibility of a department head; the giving of orders that will be carried out; the maintenance of discipline; the training of new employes; reduction of department costs; causes of labor disturbances; development of understudies; training in how to demonstrate a job, and avoidance of labor troubles at their source.

The execution of a training program of maximum quality is not a simple task, but the difficulties can be overcome without undue effort and the results will be worth while. Inadequate planning of outlines and technic dooms the plan to mediocre results, whereas the directed and precise discussion technic is the best method of eliminating the ineffectual and loose-jointed meeting.

There Must Be an Incentive

It is a recognized fact that an incentive is necessary to stimulate an employe to efficient performance and it is difficult to find a more compelling motive than the financial one to urge him on to greater efficiency. But in spite of the magical powers of money, we should also seek other ways of encouraging personnel response.

Appealing to the worker's creative ability is one method of arousing him to greater interest in his contribution to the institution and, thus, to greater service to its management.

The worker should be informed of the cost elements of his job as related to the entire organization. It has been shown in individual cases in which department costs are given to those responsible that interest is invariably aroused and a progressive reduction in cost results.

Promotion plans should be developed wherein each worker is in line for a higher position as his training and ability merit such advancement. Training programs should be made available to all workers who are interested in advancing themselves.

If we educate and inform our employes of the purposes and objectives of the institution and let them know what plans are formulated for the future then we shall have interest, cooperation and an incentive to do better work.

Student Mary Jones

MARY VESTA SOURS
CHIEF OPERATING ROOM SUPERVISOR
TUORO INFIRMARY, NEW ORLEANS

"Assigned to Surgery"

Whether Mary will develop into a first or second rate surgical nurse will depend largely on the skill and tact of those who train her for this vital and exacting work

THOSE of us who have anything to do with nursing education understandably doubt whether in this changing world any degree of stabilization will ever be achieved in this specific field. Perhaps stability would not really be desirable.

Nursing students were formerly taught a great deal that was erroneous and had better be forgotten. There was waste of time and waste of effort. By modern criteria our students were ill fitted for the practice of nursing.

They Were Trained for a Profession

At the best, it could scarcely have been otherwise. Medicine, surgery and nursing have been revolutionized in the last seventy-five years for one thing, and for another the best educational facilities of the early days were still inadequate. Nevertheless, the serious students of that period had something that all too many of even the best students lack today, a realization that they were trained for a profession as contrasted with a business—a profession that had a peculiar dignity, its own sense of value of human life, its own special concepts of conduct, behavior and action and a regard for the professional secret. They recognized the "durable satisfactions of life."

We are primarily interested in the training of operating room nurse assistants and the teaching of operating room technics to student nurses.

When students are assigned to surgery they should be given a short

period of orientation. They should be taken through the department, made acquainted with its importance and layout, its relation to the rest of the institution and the various services and, in general, told what is expected of them as students. They should be made to realize that they are "cogs in the wheel" and their part in this wheel is an important one.

We Must Win Their Confidence

Surely, an effort should be made to win their confidence and, as professional association continues, this confidence should be strengthened. We have found it expedient to provide our students with written forms that summarize in brief their duties in the operating room. It cannot be denied that when a student is posted for the operating room service, in a majority of cases she is, so to speak, "scared to death." Why? Frequently, it is because of the experience of another student who was truly scared and who had not had this period of orientation but was immediately put into the operating room and expected to click when surgery was at its highest pitch. Consequently, she was often the victim of embarrassment. This embarrassment or, rather, unfair deal had paralyzed a potentially good nurse.

There is no doubt that these suggested helps are highly beneficial to a newcomer in the department. It gives her a feeling of security and she feels more acclimated. I think we have to consider that this field

is difficult for a new student, that it is quite different from any phase of hospital work she has experienced heretofore.

We have found that each operating room should be staffed with a graduate nurse and two students in order to achieve the degree of efficiency that is needed in a department running a heavy service; that each room should function as an independent unit in itself, and that specific services should be assigned to the same rooms routinely. It is an undeniable fact that tension prevails in every operating room; however it is lower under this regime.

Tension Considerably Lessened

There is no aggravation so great as the constant changing of nurse or doctor assistants to a busy surgeon. Consequently, to run each room as an independent unit lessens tension, saves effort and waste, hastens the work and makes for more efficient service and teamwork, which, in turn, means a smooth-running service. The nurse is able really to assist intelligently because she can anticipate the surgeon's needs and is better able to train her students.

Our students receive a three months' course in operating room work with preparatory training of ten hours in operating room technic. They are given a rotation of the various operative services. In evaluating the student's ability we have often found that it is advantageous both to her and to the department

to give her major surgery first, while in some cases the opposite is true, especially of a reticent, timid student and of one who shows no special aptitude for the work. In these cases it seems better to give the students minor scrubs first.

Operating room work requires a special adaptation. Definitely, nurses should have a special interest for it. Some have intimated that surgery is mechanical, which is certainly a false notion. Nowhere in the hospital are keenness of mind and quick thinking more essential and quick acting more necessary than in surgery. We know from experience that a given schedule does not always follow and that allowances sometimes have to be made for unexpected changes. We know, too, that mistaken diagnoses require an altogether different procedure than the one anticipated.

In these instances the nurse must be able to cope with the situation intelligently and efficiently. This requires her to be "fast on the trigger"

and makes her invaluable as a surgical assistant. Almost anyone can wear gloves for an hour or so and dress in sterile gown and pose at a table. I sometimes find that we have too many of this brand of surgical nurses. What a doctor wants is a girl who is awake and sensitive to his needs. Surgery requires a keen sense of duty, a fear of God, a dependable nature and the ability to work long hours at a stretch cheerfully and uncomplainingly.

In my experience in training and in working with nurses as supervisors, some with fair experience, some with better than fair and some with the added qualifications of a postgraduate course, I find these nurses inadequately trained for the job. They have in many instances had training only in one phase of the subject of surgery and often this training is meager. Certainly, in the majority of instances (I have had applicants from almost every section of the country) their experience and

training are limited; they are inadequately prepared.

Long ago I reached the conclusion that many so-called postgraduate courses are courses of cheap labor for the hospital. A postgraduate course should take in all branches of surgery or it is not a postgraduate course in surgery. These nurses have had no training in the economics or the administrative duties of a surgical suite.

There is no place in which administrative ability is needed more than in surgery. One has the opportunity to meet all kinds of people and, generally, sees them when they are at their worst. The surgery offers a good cross-section of all types of personalities and temperaments. Again, there is no place in the hospital in which expense is as great as it is in a surgical department. Equipment is expensive, supplies are costly. Also, there is no place in the hospital in which time can be saved to greater advantage.

For these reasons economics and administration are vitally important to the training of both a nurse who expects to follow surgery as her field and the young student. It gives them an idea of the cost of upkeep and tends to cut down waste. We have found it advisable to give our students and assistants some idea of the overhead of our department each month. This curtails waste.

In conclusion, we feel that to let each service or given room function independently makes for a smooth efficient service, for cooperation and a better feeling (for a surgeon is happiest when he is served efficiently). It develops keenness of perception, clinical acumen and technical skill in the nurse and makes her a dependable assistant. I think it true, indeed, that when the surgery is efficient the hospital is efficient for it has been said that an operating room service either makes or breaks a hospital.

Kipling set it down this way: "Hard toil, high courage, eternal sacrifice, bitter disappointment, by these things are visions translated and dreams brought to pass." Let it be our aim, therefore, to train with patience, kindness and a thoroughness that will include a definite and adequate teaching and clinical program, to achieve our purpose of producing good substantial operating room nurses. We need them.

Victory Through Sacrifice

JOHN F. CRANE

MONTEFIORE HOSPITAL, NEW YORK CITY

THE hospital administrator has the best of reasons for knowing that we and our Allies are literally engaging in a life and death struggle. He has a war, which is peculiarly his own, on his hands as part of his daily struggle for life. There are, however, some among us who are prone to forget that sacrifices must be of equal importance with valor on the field if we are to hasten the end of the conflict.

Having full knowledge, from personal experience in the last war, of the sacrifices demanded from the members of the armed forces overseas, I was surprised to learn the reason a hospital employe gave for leaving his work, *i.e.* that, occasionally, his bed was not made up and that on some days his room was not thoroughly cleaned. Comment on such incidents should be superfluous. Good administrative technic requires, however, that serious consideration be given to the enlightenment of hospital employes who need it.

Inasmuch as the administrator can-

not be everywhere at the same time, it might be well for him to administer the introductory lecture and to assign the remainder of the educational task to a member of the staff who has seen action, is on leave and has the gift of speech. If he has seen service overseas and knows, from observation, how the rest of the world lives, so much the better. A few heart to heart talks will accomplish more than a wall covered by posters.

The employe referred to is not representative of hospital employes generally. We know that when he and his kind are called to sacrifice, whether it means less of their customary food, time off duty or the payment of taxes, they will respond as those persons, holding the fort for us, have already responded in Britain, Russia, China and in the friendly occupied countries. They should be told, in case they do not know it, that our enemies are sacrificing, too, and that victory may come to him who sacrifices most.

Practical Procedure for Oxygen Therapy

PRISCILLA HOWLAND, R.N.

Nursing Arts Instructor, Stamford Hospital, Stamford, Conn.

AS AN aid to the nursing staff in administering oxygen therapy, Stamford Hospital, Stamford, Conn., has set up the accompanying standards of procedure, which have proved to be useful and practical from the nursing point of view.

In order to acquaint the nurse with the general field of oxygen therapy, the standards define the purpose of

oxygen administration, *i.e.* to supply oxygen in conditions in which there is some interference with the normal oxygenation of the blood, and summarize the causes of diminished supply of oxygen to the blood, the conditions for which oxygen is used and the indications for its use. Also included is a list of general precautions that must be observed in the handling of oxygen equipment.

GENERAL PROCEDURE—(Cared for by service agent):

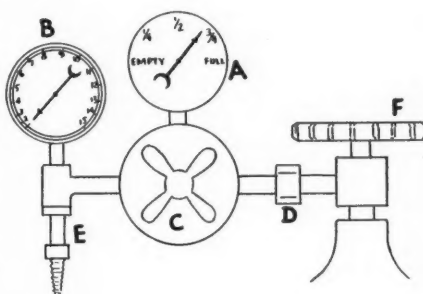
1. "Crack" the oxygen tank by opening tank valve F (counter-clockwise) very slightly until a hiss of escaping gas is heard. This is done to blow out any dust that may have collected in the nozzle of the tank valve.
2. Attach regulator to cylinder valve F by means of nut D and tighten with a wrench.
3. Loosen handle C by turning counter-clockwise until free and open cylinder valve F very slowly. The contents of the tank will register on gauge A.
4. Turn handle C clockwise to obtain flow of oxygen desired. The rate of flow will register on gauge B.
5. The type of apparatus to be used is now connected to the threaded outlet E.

OXYGEN CHAMBER—Procedure:

1. Keep all possible sources of fire away from chamber.
2. All electrical switches must be outside of the chamber.
3. Use **NO ELECTRICAL APPLIANCES** at the bedside.
4. Carry out nursing procedures as usual with observance of the fire precautions.

OXYGEN TENT—Procedure:

1. Fill the ice chambers with pieces of ice approximately the size of a quart measure.
2. Explain procedure to patient assuring him that oxygen is used to relieve his distress and discomfort. Never allow him to entertain the idea that he has suddenly become worse. It may even be advisable to suggest that this treatment is merely a means of adequate "air conditioning."
3. Place tent at back of bed and unloosen canopy extending it and frame over bed.
4. Insert electric plug of motor into electric wall socket.
5. Always have motor on before placing tent over patient. To start motor turn switch to "on" position. (The pilot light becomes illuminated when motor is running.)
6. Tuck the edges of the canopy securely under mattress but leave windows open.
7. Attach regulator to cylinder.
8. Connect tent to cylinder by means of rubber tubing and nipple at E.
9. Close all zipper fastenings.
10. Regulate flow of oxygen to 15 liters



per minute for thirty minutes to provide oxygen saturation in the tent. Then reduce to 10 or 12 liters to maintain concentration. (If transparent canopy is used 8 or 10 liters are sufficient. This canopy has smaller cubic content.)

11. Open water drain and place drain pan under outlet.

12. Adjust rheostat to intermediate position or to high or low as needed to maintain correct temperature of 64°-68° F.

(a) If the tent becomes too cold: move rheostat to the "slow" or warm side, remove some of the ice from the chamber and apply hot water bottles around patient.

(b) If tent becomes too warm: replenish ice supply, make sure plug is in wall socket and the motor is running, keep water drain open and check to see that water is running from it and move rheostat to "fast" or cold side.

(c) The ice compartment should be checked every four hours or more often if necessary. The motor switch should be turned off before the lid of the ice chamber is opened.

13. Oxygen analysis should be made regularly.

14. Turn off motor before any zipper is open more than a few inches.

NASAL CATHETER—Equipment:

Cylinder
Regulator
Humidifier
Nasal Catheter

PROCEDURE:

1. The catheter should be perforated within its terminal inch by six or eight small holes.
2. Regulate oxygen flow—usually from 4 to 6 liters per minute.

3. Lubricate the end of the catheter with vaseline, not a light oil.

4. To introduce catheter into oropharynx, the distance is determined by measuring the space between the tip of the nose and the lobe of the ear; the catheter is inserted this distance into the nose and withdrawn about 1/4 inch, or until the patient swallows oxygen.

5. Bend the catheter along the bridge of the nose or along the side of the face and over the ear or forehead and tape it securely in place.

6. SPECIFIC PRECAUTIONS:

(a) Keep humidifier 1/2 to 2/3 full of tap water at all times. Water may be added by unscrewing the glass part of the water bottle from the metal cap (unscrew carefully as glass breaks easily under strain).

(b) Catheters should be removed every 6 or 8 hours for cleansing. Rinse with cold water. Wash with soapy water and drop into boiling water for five minutes.

(c) If a single catheter is used, use the alternate nostril when reinserting (unless obstruction prevents).

FORKED NASAL CATHETER, BULLOWA, METAL CANULLA—Procedure:

1. Regulate flow of oxygen at the rate specified, usually from 4 to 6 liters per minute.

2. Adjust metal tips to individual and insert into nostrils but do not completely occlude nares.

3. Strap inhaler securely to head.

4. Cleanse the same as nasal catheter.

NASAL OR FACE MASK—Procedure:

1. Regulate flow of oxygen at a rate sufficient to keep bag from completely deflating on inspiration.

2. Fit mask to face.

3. Ensure proper adjustment by noting the reservoir rebreathing bag. The bag should not completely collapse upon inspiration and should expand nearly to capacity upon expiration.

4. To maintain comfort the mask should be removed approximately every 2 hours and the face washed, the skin dried and a light covering of talcum powder applied.

CHARTING OF OXYGEN THERAPY:

Record: (1) type of administration, (2) time started, (3) time discontinued, (4) concentration of oxygen used, *i.e.* liter flow, (5) cylinder numbers and (6) objective and subjective symptoms.

Where to Find the Facts—

GERHARD HARTMAN

THERE are two distinct ways in which the present rapid development of sources of information can be approached.

One way is to search for specific sources, such as particular agencies that disseminate information. The second approach concerns itself with the development of critical attitudes for the appraisal of the quality of the sources of information once they are determined. Both aspects will be examined in this discussion.

At the present time there is no complete body of literature in the hospital field. The few bound books are merely an introduction to some of the more important problems. The best sources of information are the leading hospital journals and the Transactions of the American Hospital Association.

It may be well to point out that there has been a renaissance in hospital thinking. This is clearly brought out in the number of new books that have been published or are now in preparation. They indicate that the hospital field is becoming mature and will be entitled to recognition as a professional or quasi-professional entity among the fields of learning.

Books are not a final answer, however. The material that finally finds its place among the more nearly permanent records of information is gleaned from the articles in the hospital journals, reports of study committees and the findings of a multitude of agencies, information that is being constantly reshaped to meet changing demands.

From the point of view of organization and management, hospital administration is one of the most complex fields extant. It draws its information from both the basic and the applied sciences, physical and social. Hospital administrators must develop a unique attitude to the various findings of the sciences. This attitude can best be expressed by a brief statement, namely, that the administrator need not know all about everything but must know the significance of everything.

As hospital administrators become skilled in the use of sources of information they will grow in competence. No administrator need be ashamed or afraid to use primary sources of information as long as

due credit is given and satisfactory acknowledgment is made. Specific sources of information for such a complex field are multiple and varied.

A brief list of sources, some of which are comparatively well known and others generally neglected, is given here. This list is not intended to be complete but rather to indicate the variety of sources that may be consulted for further exploration.

Two examples of how these sources may be adapted to meet actual problems can be cited.

An administrator of a hospital would like information on which to base a decision about rehabilitating some of the furniture used in the

hospital both for patients and for administrative purposes. What are some of the sources that may be consulted for technical guidance? Probably the best technical source would be the publications of the United States Forest Products Laboratory at Madison, Wis. Another would be the reports of the extension divisions of our leading universities.

Another source available in bound form is "Institutional Housekeeping" by Crete M. Dahl. A final source that may be useful in giving technical information on domestic furniture is to be found in the bulletins of Consumer's Union, an organization intended to serve its subscribers

Specific Sources of Information

United States Government

Particular attention is called to the Monthly Catalog of U. S. Government Publications. The catalog lists by departments publications of the government that may be obtained either by request or by purchase. It also lists publications issued for departmental use only. The domestic yearly subscription is \$1.50.

Department of Agriculture, Washington, D. C.
Agricultural Marketing Service.
Bureau of Agricultural Economics.
Bureau of Home Economics.
Extension Service.

Department of Commerce, Washington, D. C.
Bureau of the Census.
National Bureau of Standards.

Department of the Interior, Washington, D. C.
Bureau of Mines.

Department of Labor, Washington, D. C.
Bureau of Labor Statistics.
Children's Bureau.
Division of Labor Standards.
Women's Bureau.

Department of the Navy, Washington, D. C.
Bureau of Medicine and Surgery.

Federal Security Agency, Washington, D. C.
Food and Drug Administration.
Office of Education.
Public Health Service.
Social Security Board.

Federal Trade Commission, Washington, D. C.
Among the administrative divisions of the commission are a medical advisory section and a hospital section.

Federal Works Agency, Washington, D. C.

Veterans' Administration, Washington, D. C.
Construction Service.
Medical and Hospital Service.
Special Service.
(These divisions are under the assistant administrative officer.)

Associations

Advisory Board for Medical Specialties, 416 Marlboro Street, Boston. (Improves methods of graduate education and training in medical specialties and, through its constituent boards, certifies qualified specialists.)

American Association of Social Workers, 130 East Twenty-Second Street, New York City.

American College of Hospital Administrators, 18 East Division Street, Chicago.

American College of Physicians, 4200 Pine Street, Philadelphia.

American College of Surgeons, 40 East Erie Street, Chicago.

American Committee on Maternal Welfare, 650 Rush Street, Chicago. (Stimulates interest of medical profession in cooperating with public and private agencies for protection of mothers and offspring.)

American Dental Association, 222 East Superior Street, Chicago.

American Dietetic Association, 185 North Wabash Avenue, Chicago.

American Institute of Accountants, 13 East Forty-First Street, New York City. (Maintains reference and circulating library and bureau of information.)

American Hospital Association, 18 East Division Street, Chicago.

American Library Association, 520 North Michigan Avenue, Chicago.

American Management Association, 330 West Forty-Second Street, New York City. (Provides information and research service in business organization and management.)

American Medical Association, 535 North Dearborn Street, Chicago.

American Nurses' Association, 1790 Broadway, New York City.

American Pharmaceutical Association, 2215 Constitution Avenue, Washington, D. C. (Prepares and keeps up to date the National Formulary; furthers standardization of pharmaceutical formulas.)

American Public Health Association, 1790 Broadway, New York City.

American Social Hygiene Association, 1790 Broadway, New York City. (Employs consultants available for field studies and advice to local groups.)

American Society for the Control of Cancer, 350 Madison Avenue, New York City.

American Public Welfare Association, 1313 East Sixtieth Street, Chicago.

American Standards Association, 29 West Thirty-Ninth Street, New York City.

How to Interpret Them

Administrator
Newton Hospital, Newton Lower Falls, Mass.

in a confidential manner by giving appraisals on the quality and prices of various branded products.

Another question of real importance in the hospital field is the most efficient purchase of perishables. An excellent published source is the "Handbook of Fruits and Vegetables" by the U. S. Department of Agriculture. This remarkably complete booklet indicates the specific seasons, right down to the week, in which the best purchases can be made on the basis of supply in various regions of the country.

The second source, which appears to be rather remote and yet can be a real contribution, is the home mar-

keting sections of newspapers. Their information on home products and their recommended menus for various classes of meals can easily be adapted to hospitals by intelligent administrators, purchasing agents and dietitians. In rural areas administrators can look to the county agents of the Department of Agriculture for guidance.

Turning now to the intellectual processes or steps into which every administrative problem must necessarily be reduced, we find that the following are either consciously or unconsciously observed: (1) statement of the problem and its general objectives; (2) review of a number

of sources of information, including literature and persons with whom the administrator may confer, either personally or by correspondence; (3) statement of the specific solution in relation to particular circumstances; (4) reorientation of the particular solution in relation to the basic trends in the hospital field.

The degree of completeness with which an administrator analyzes his problems will determine his ability to handle them successfully from both a technical and an administrative point of view. His success in adapting published information to their solution depends upon his being able to evaluate the soundness of the author's material.

Space does not permit a full exposition of the many tests that must be applied to determine the quality of any article or idea or to test its particular usefulness in relation to definite purposes. In examining the material in regard to the author's soundness of reasoning, the following questions may be asked by the reader: Is the author guilty of any of the following fallacies:

1. Does the author take isolated quotations from one field and use them in his arguments in such a way as to misrepresent the first author's views?
2. Does his work use analogies improperly in order to prove a point?
3. Does the author overgeneralize from particular information to general conclusions?
4. Does the author speak exclusively in the first person and reflect only his own attitudes or does he develop his arguments in the light of the experienced judgments of other authorities on the subject?

This last named is probably the greatest fault found in technical writing. The author assumes that because some method, procedure or plan was successful in his hospital it should be extended to all hospitals.

The foregoing are only a few of the fallacies commonly found in hospital writing.

Hospital administrators must recognize that they occupy strategic positions in the health and welfare of the nation. They should, therefore, open their minds to an intellectual conception of their problems and carefully apply existing knowledge to present needs.

for the Hospital Executive

American Statistical Association, American University, Washington, D. C. (Studies the collection and interpretation of statistical data and seeks improvement of statistical methods and data. Has a committee on hospital statistics.)

Association of American Medical Colleges, 5 South Wabash Avenue, Chicago.

Canadian Medical Association, Hospital Division, 184 College Street, Toronto, Ont.

Catholic Hospital Association, 1402 South Grand Boulevard, St. Louis.

Educational Buyers' Association, 45 Astor Place, New York City. (Serves as clearing house for purchasing information; maintains collection of tests and investigations.)

Hospital Bureau of Standards and Supplies, 247 Park Avenue, New York City. (Maintains a central purchasing agency for members; promotes simplification and definite specifications for hospital supplies.)

National Association of Purchasing Agents, Inc., 9 Park Place, New York City. (Maintains research department which assists members in locating sources of supply; develops information of purchasing problems.)

National Board of Medical Examiners, 225 South Fifteenth Street, Philadelphia.

National Executive Housekeepers' Association, 521 West One Hundred and Twelfth Street, New York City.

National Hospital Association, 4666 South State Street, Chicago. (Devoted to the development of administration in Negro hospitals.)

National League of Nursing Education, 1790 Broadway, New York City.

National Organization of Public Health Nursing, 1790 Broadway, New York City.

Puerto Rican Medical Association, San Juan, Puerto Rico.

Puerto Rico Hospital Council, San Juan, Puerto Rico.

School of Tropical Medicine, San Juan, Puerto Rico.

Public Administration Service, 1313 East Sixtieth Street, Chicago. (Makes administrative surveys; devises systems for scientific measurement of governmental activities.)

Funds and Foundations

Commonwealth Fund, 41 East Fifty-Seventh Street, New York City.

Carnegie Foundation, 522 Fifth Avenue, New York City.

Duke Endowment, Power Building, Charlotte, N. C.

Kellogg Foundation, Battle Creek, Mich.

Milbank Memorial Fund, 40 Wall Street, New York City. (No longer active in the field of medical economics, although previous publications are worth while.)

Rockefeller Foundation, 49 West Forty-Ninth Street, New York City.

Rosenwald Fund, 4901 Ellis Avenue, Chicago. (No longer active in the field of medical economics, although previous publications are worth while.)

Twentieth Century Fund, 330 West Forty-Second Street, New York City.

Russell Sage Foundation, 130 East Twenty-Second Street, New York City.

Additional Sources of Information

Bacon Library of the American Hospital Association.

Local hospital councils.

Local newspapers.

Local public libraries.

University libraries.

Special research and reference libraries, such as the Library of Congress; John Crerar Library, Chicago, and Grosvenor Library, Buffalo.

Books

"American Foundations and Their Fields," Compiled by Geneva Seybold, Raymond Rich Associates, New York, 1939.

"Philanthropic Foundations and Higher Education," Ernest V. Hollis, Ph.D., Columbia University Press, 1938.

"Public Administration Organizations," Public Administration Clearing House, 1313 East Sixtieth Street, Chicago.

"The Hospital Yearbook," Modern Hospital Publishing Company, 919 North Michigan Avenue, Chicago.

"United States Government Manual," Office of Government Reports, Washington, D. C.

"If the Worker Hasn't Learned the Instructor Hasn't Taught"

HOSPITALS in various parts of the country are finding that the Training Within Industry program of the War Manpower Commission holds a great deal of value to them. This program was first described for hospitals in an article by Ellen Aird entitled "You Can Keep Employees," published in *The Modern Hospital* for December 1942.

Recently, hospitals in Pittsburgh arranged to have the job instructor training offered to their department heads and 238 persons completed the courses. In May a course was taken by a group of Chicago housekeepers.

One of the housekeepers registered in that course, Mrs. Orpha Daly of MacNeal Memorial Hospital, Berwyn, Ill., has prepared some typical job breakdowns. These are reproduced to illustrate the basic training instructions of the T.W.I. program, which are here published with specific permission of C. R. Dooley, director of the T.W.I. program. The phraseology has been modified slightly to make the instructions applicable to hospitals.—Ed.

HOW TO INSTRUCT

You are about to instruct a man how to do his job. This is highly important to the man, to you and to your hospital.

Perhaps the man has been with you for years. Perhaps he has been transferred to you. Or maybe he is green—starting his first job. Or perhaps he has had long experience in another industry and is starting his new work in the hospital.

Here are some ideas that may help you. They were worked out by others, just like yourself, who had the same job to do. Study them. Use them. They are easy to follow.—C. R. DOOLEY, director, *Training Within Industry*.

What You Want to Do

Go back in your own memory. Remember how you felt the first day

on a new job—the time you were "stumped" by a new "wrinkle" on the job, the time when you wasted some material, the time you got hurt, the times when the boss corrected you and your work? Perhaps you liked the way he did it; or perhaps you didn't?

Any worker assigned to you feels the same way. He wants to make a good showing. You realize this. You are interested in four things:

1. Having the new worker come up to the quality and quantity requirements of his job as quickly as possible.
2. Avoiding accidents that will injure the worker.
3. Avoiding damage to machines or equipment.
4. Wasting as little material as possible.

How You Can Do It

Most of us just "jump right in" and start instructing or correcting a workman without much thought or planning. Perhaps you do the same.

You know the job so well that you've forgotten the things that "stump" the learner.

You know it so well, that you don't *plan* how to "put it over."

You know it so well that you don't pick out the "key points," the "knacks," the things that make or break the operation.

To instruct a man *rightly* takes just a little extra time at the moment, but it saves hours and days of time later on, and prevents a large part of the waste and accidents. The following plan is simple and easy to follow. Furthermore, it works.

Before instructing, there are four "get ready" points for you to watch. You can do them in a few minutes.

When instructing there are four basic steps to follow. They really are no different from what you may now be doing. But they help you do it well and thoroughly. At least they have helped thousands of others.

How to Get Ready to Instruct

Here are the four GET READY points you should take care of before instructing:

1. *Have a timetable:* How much skill do you want the man to have? How soon?

When faced with a "breaking in" problem, don't say what all too many of us say: "It takes time," or "he just has to learn." Say to yourself instead: "How much time?"

Here is an easy way to do it. Answer to yourself this statement: "(employee) should be able to (do what job) and do it (how well) by (what date)." Better yet, put down the names of personnel on a piece of paper. Set yourself some dates when you are going to try to have them able to do the jobs they need to know. *Time is short.* Have a timetable for yourself and your men.

2. *Break down the job.* You know there is one right way to do every job. You know, too, that there are a few "key points" in every operation that make or break it. If these key things are done rightly, the whole operation is right. If any one of them is missed, the operation is wrong.

If you put the job over to the worker with these key points made clear, he will really "get it." He will do the operation right the *first time*. He won't be "fighting" the work—making mistakes.

There is an easy, quick way to get the job clearly outlined in your mind. Fill out a "breakdown sheet," such as those shown in the accompanying samples, for each of your operations. It takes only from three to five minutes. This is for your own use.

3. *Have everything ready,* the right tools, equipment and materials. When you so much as "touch" a job in front of a worker, set the correct example.

4. *Have the work place properly arranged,* just as the worker is expected to keep it. The same thing

applies here as above. You must set the correct example. Put his bench or desk or wherever he is to work in proper order before you start to put over the job to him. *He* won't do it if *you* don't do it.

How to Instruct

Here is what you should do every time you instruct a man or correct his work:

Step 1—Prepare the worker to receive the instruction.

Put him at ease. Remember he can't think straight if you make him embarrassed or scared.

Find out what he already knows about this job. Don't tell him things he already knows. Start in where his knowledge ends.

Get him interested. Relate his job or operation to the patient, so he knows that his work is important.

Put him in the right position. Don't have him see the job backwards or from any other angle than that from which he will work.

Step 2—Present the operation.

Tell him, show him, illustrate, ask. "Put it over" in small "doses." He (the same as all of us) can't learn but six or eight new ideas at one time and really understand them.

Make the "key points" clear. These will make or break the operation—maybe make or break him.

Be patient and go slowly. Get accuracy now; speed later.

Repeat the job and the explanation if necessary.

Step 3—Try out his performance.

Have him do the job, but watch him.

Then have him do it again, but have him explain to you what he is doing and why. All of us find it easy to observe motions and not really understand what we are doing. You want him to understand.

Have him explain the key points. Correct his errors, but don't bawl him out or indicate that he is "thick" or "dumb."

Continue doing all this until you know he knows. He may have to do the job half a dozen times.

Step 4—Follow-up.

Put him on his own. He has to "get the feel" of the job by doing it himself.

Tell him to whom he should go if he needs help. Make this definite, i.e. yourself or someone *you* designate. The wrong person might give him a "bum steer."

CLEANING AN OCCUPIED ROOM

STEPS

1. Clean rug with carpet sweeper. Clean with vacuum cleaner once a week.
2. Dust floor with dry mop.
3. Dust all furniture.
4. Dust windows, sills and window shields, wood work and hardware.
5. Clean face bowl and plumbing.
6. Empty and clean wastebasket.
7. If there are dirty spots on floor, wipe them up with wet cloth.
8. Wash floor every other day, except in unusual cases, which might require washing the floor every day.

KEY POINTS

1. Do not bump bed or furniture with cleaning tools, as this annoys the patient and mars the furniture. When vacuum cleaner is used also clean the floor with it.
3. Be careful to dust all hidden corners.
4. Wash when needed.
5. Dry all nickel or chrome plate.
8. When rug is vacuum cleaned, also wash the floor. This makes the patient feel the room is thoroughly cleaned.

CLEANING AND MAKING UP A VACANT BED

STEPS

1. Remove soiled linen from bed.
2. Wash rubber sheet.
3. Dust mattress and turn.
4. Elevate head and foot of bed spring.
5. Wash all parts of bed and spring.
6. Lower head and foot of bed spring.
7. Center mattress pad on mattress.
8. Place first sheet on bed.
9. Tuck sheet under head end of mattress.
10. Miter corners of sheet at head of bed.
11. Tuck sides of sheet under mattress.
12. Place rubber sheet on bed and powder both sides of rubber sheet.
13. Center rubber sheet between head and foot of mattress.
14. Place draw sheet on top of rubber sheet.
15. Tuck ends of draw sheet and rubber sheet under sides of mattress.
16. Place top sheet on bed.
17. Place blanket on bed.
18. Fold top end of sheet back over top of blanket.
19. Place wash spread on bed.
20. Tuck sheet, blanket and spread under foot of mattress.
21. Miter corners of all three securely at foot of mattress.
22. Cover pillows with pillow slips.
23. Place pillows at head of bed.
24. Cover bed with top spread, if one is used.

KEY POINTS

1. Remove each piece of linen separately watching for instruments or patient's belongings.
2. Place on back of chair to dry.
3. Brush with whisk broom.
5. Thoroughly clean construction underneath bed.
7. Center fold of all bedding should be placed in center of bed.
8. Place sheet right side up, with bottom end of sheet even with foot end of mattress.
- 9-11. Be sure sheet is tucked in smoothly and securely.
15. Tuck in securely so they will stay in place.
16. Wrong side up, with top end of sheet even with head of mattress.
17. Top end of blanket should be 12 inches below head of mattress.
19. Have top end of spread even with top of blanket.
22. Fold end of slip in over end of pillow.
23. Have open end of slips facing in the same direction.
24. Adjust spread at head and foot of bed, being careful to have it even on each side. Cover foot end of mattress and spring, but do not tuck spread in. Cover top edge of pillows and tuck surplus under bottom edge of pillows.

Check him frequently, perhaps every few minutes at the start to every few hours or few days later on. Be on the lookout for any incorrect or unnecessary moves. Be careful about *your* taking over the job too soon, or too often. Don't take it over at all if you can point out the helps he needs.

Get him to look for key points as he progresses.

Taper off this extra coaching until he is able to work under normal supervision.

Use this plan. You will find it amazing that such greatly improved results can come from such a simple plan.

COLOR Comes Into Its Own

SMALL hospitals throughout the United States are using much more color in their decorative plans, according to a survey made of 16 institutions in various sections of the country.

All but two have experimented with color and are enthusiastic over its effect upon patients, personnel and public. Even those that still adhere to the more conservative ivory tints agree that a colorful hospital contributes to better personnel and public relations. The institutions reporting range from 25 to 125 bed capacity.

Private Rooms Come First

Color enters the hospital first through private rooms where suitable tints take the place of the traditional buff and ivory. Once favorable response is assured, which invariably happens, the decorative plan is extended to include the front entrance or foyer, the wards, staff and employees' quarters and other areas. Of the 16 hospitals studied, 12 have redecorated the private rooms, eight, the foyers, seven, the wards, four, the help's quarters and four, other areas.

Paint is the medium through which most hospital walls are assuming new interest, therapeutic importance even, although wall coverings are gaining in popularity. Despite a somewhat larger initial cost, these coverings are conceded to be economical over the long term. Among other attributes, they conceal effectively any defects in the plaster surface and their application requires a minimum of time in which the room remains unoccupied, which is something to be considered in days when the demand upon hospital facilities is constantly increasing.

There is no longer any question

There is one subject on which small hospitals agree and that is the growing importance of color. Of 16 replies received to this month's query on interior decoration, 14 hospitals report that color plays a big rôle in their decorating plans—and they are convinced of its value as a builder of better public relations

that certain wall coverings can be washed and cleaned successfully. Three of the hospitals reporting have experimented and are enthusiastic over the results. These coverings, some of which introduce suitable patterns, are particularly successful in reception rooms, sunrooms and dining rooms, although private rooms and wards are being similarly treated. There is a disposition to be conservative in the matter of wall pattern, contrast in color and design being accomplished through curtains and upholstery materials.

Green is acknowledged to be the leading hospital color because of its soothing, restful qualities. Furthermore, there is less risk in experimenting with tints of green than with other colors—blue, for example. A note of warning should be observed, however, when selecting from color charts to make sure that the green has no yellow cast. However pleasing it may be elsewhere, the patient's room is not the place for yellow-green. Blue-green, on the other hand, is an ideal hospital color, always restful to the eye yet never growing monotonous.

Ten of the 16 hospitals included in the survey have featured green in their color schemes. Blue comes next with five endorsements to its credit. Other colors in their selected order are ivory, peach, rose, pink, rust, tan, yellow and buff.

How Color Is Distributed

It is interesting to note how these colors are distributed. Sister Maria of Bethlehem, superintendent of Our Lady of the Rosary Hospital, Castor, Alta., uses rose, pale green and pale blue for her patients' rooms, with yellow for the halls and the entry.

In Riverview Hospital, Wisconsin Rapids, Wis., J. K. Goodrich explains that in the new building they have used color according to the type of occupancy and exposure as recommended in *The Modern Hospital* chart. "We have received countless compliments and no adverse criticism," he asserts, adding "after fourteen months of service we would not change the colors and we would not change from eggshell finish to a high gloss."

Here are several color schemes de-

scribed by Myrtle B. Skoog, superintendent, Immanuel Hospital, Mankato, Minn.: Entrance walls are pecan gray with bone white ceiling and a cove border of Caribbean blue and dubonnet. Private rooms are treated according to location with peach bloom and pastel tints of green predominating. A nurses' restroom has two walls done in lime yellow and two in turquoise, a happy combination with which to make a basement room appear warmer.

Light Colors Predominate

Light colors are selected as well by Dr. F. A. Alcorn, superintendent, Orthopedic Hospital, Lincoln, Neb. Tints of blue, tan, pink and ivory with green in the south rooms constitute the color plan. One dining room is done in clover colored walls topped with a gray ceiling.

Color is no novelty in Massachusetts Women's Hospital, Boston. "For four years we have had colored walls with matching draperies," Mrs. Lila M. Little, the superintendent, reports. "Paint is used throughout in tones of peach, light blue and pale green."

Not only is more color being used in the Hood River Hospital, Hood River, Ore., but wall covering, too, has been applied with great success. L. M. Baldwin, financial manager, has concentrated upon well-diffused flower patterns in light and neutral colors. Another small institution in which the decorative plan includes wall coverings is St. Joseph's Hospital, Stamford, Conn. Here, Sister M. Sacred Heart has dressed up the reception alcoves, sunrooms and dining rooms in such manner that, to quote her: "All are very much pleased with the effect. It takes away any 'hospital atmosphere.'"

It is apparent that in the great majority of small hospitals the superintendent acts as his own decorator with what help he may find it possible to obtain from other sources. Twelve of the 16 reporting attest that it is up to the managing head to take the initiative. One hospital was fortunate enough to have the assistance of the architect in developing color plans; another had the services of a professional decorator, while a third acknowledges the help of the housekeeper.

One superintendent attributes the success of her decorative effect to meetings held with her department

HOSPITAL	SIGNED BY	BEDS
Orthopedic Hospital, Lincoln, Neb.....	Floyd A. Alcorn, M.D.....	110
North East Mississippi Hospital, Booneville, Miss.....	W. H. Sutherland, M.D.....	40
Southside District Hospital, Mesa, Ariz.....	Lois M. Hansen.....	48
Charles Godwin Jennings Hospital, Detroit.....	Willis J. Gray.....	79
Riverview Hospital, Wisconsin Rapids, Wis.....	J. K. Goodrich.....	85
Massachusetts Women's Hospital, Boston.....	Mrs. Lila M. Little.....	60
St. Joseph's Hospital, Stamford, Conn.....	Sister M. Sacred Heart.....	90
Steptoe Valley Hospital, East Ely, Nev.....	R. A. Bowdle, M.D.....	47
Immanuel Hospital, Mankato, Minn.....	Myrtle B. Skoog.....	75
Our Lady of the Rosary Hospital, Castor, Alta.....	Sister Maria of Bethlehem.....	25
Milford Memorial Hospital, Milford, Del.....	Ramona Breeze, R.N.....	100
General Hospital of Everett, Everett, Wash.....	Cecile Tracy Spry.....	125
Rosebud Community Hospital, Forsyth, Mont.....	Donaleen N. Viestenz.....	25
Hood River Hospital, Hood River, Ore.....	L. M. Baldwin.....	40
Greenwood Hospital, Greenwood, S. C.....	H. B. Morgan, M.D.....	80
Souris and Glenwood Memorial Hospital, Souris, Man.	Alice O'Brien, R.N.....	30

heads and the suggestions they offered. In one instance the mechanical engineer even is credited and it is not unusual for the board of directors or a committee therefrom to be involved in the proceedings. As important as it may be to check with those who are qualified to judge, it is generally agreed that the fewer concerned the better. It is impossible to get unanimous opinion from a large group in matters pertaining to color and decoration.

Everybody Likes It

On one point everyone seems to agree, and that is the reaction of visitors, patients and employees to color in the hospital. Only two of the 16 respondents indicate that there has been little comment one way or the other. Having operated a hospital both with and without color Mr. Goodrich, who has been quoted previously, states emphatically, "We would vote for color from the points of view of the patient, the visitor and the employees."

Other typical comments are: "Favorable"; "we have had some very nice compliments on the cheerful atmosphere created for the sick patient"; "they like the brighter atmosphere"; "patients find it gives a homelike feeling."

Myrtle B. Skoog of Mankato, Minn., goes even farther. She adds

that the employees of Immanuel Hospital have taken much interest in the color schemes and that "we have even had women come in to see our decorating before doing their own."

Improves Public Relations

Similar unanimity is evidenced in answers to the question as to whether a colorful hospital contributes to better personnel and public relations. Fourteen reply "yes"; the remaining two agree "to some extent." None answers negatively.

Particularly significant are these reports in formulating postwar plans. That the hospital of the future will be more colorful is the decree of architects, consultants and builders, as well as of executives and department heads. In the days following the war we shall have greater need than ever before for more color in mending not bodies alone but minds tortured by shock and stress.

These 16 small hospitals have shown what can be done and the beneficial results from the effort. Others might well follow suit, if not by actual accomplishment of a carefully conceived plan of interior decoration at this time, then by studying color charts, consulting with authorities and developing a color plan that can be adopted immediately the sirens signal peace.

British Hospitals Look Ahead

When the Beveridge plan becomes a reality, will British voluntary hospitals remain voluntary or will local government authorities control them?

S. R. SPELLER, LL.B.

Editor, *The Hospital*, London, England

ONE would not need to be an overbold prophet to say that assumption "B" of the Beveridge report, postulating a comprehensive national health and hospital service free (with trifling exceptions) to all persons in case of need, is likely to be put into effect soon after the war, whatever the complexion of the post-war government.

That this is the view of the medical profession is clear from the terms of a resolution submitted to the representative body of the British Medical Association on March 31. This resolution makes the support of the organized medical profession for the implementing of the health side of the report conditional upon the acceptance of the other recommendations.

Doctors Are Worried

The doctors fear that recommendations that affect such financial interests as the powerful insurance companies and the unsatisfactory "approved" societies associated with them might be shelved and the public pacified with an extended health service on terms that will penalize the medical profession.

Actually, that is not likely to happen, for there is a strong feeling amongst the common people that only the Beveridge scheme in its entirety would provide the necessary minimum of security and that, once the demands of war are out of the way, the public will brook no denial of its claim to the unqualified acceptance of the report.

This seems to be appreciated by the government and conversations

are already taking place with the doctors, with local authorities responsible for public hospitals and with voluntary hospitals. Similar consultations are to take place with pharmacists and dentists. And where is it all leading? The position seems to be as follows:

1. Group general medical practice carried on by groups of doctors from "health centers" in each locality is certain to come and to be free to all, or to all who pay the "national security contribution" under the Beveridge scheme and to their families.

It is unlikely that the medical staff will work on a whole-time salaried basis at the beginning, for most doctors are against it, but many of us wonder how long private practice can survive if the new scheme gives good service—and if it doesn't, it is not worth while.

2. School medical services, prenatal and infant welfare clinics and similar health services will probably be organized and directed from the health centers.

3. There were already clear indications before the Beveridge report appeared that a fully coordinated hospital service was envisaged by the government and recognized as inevitable both by the local authorities and by the voluntary hospitals. The struggle is as to the form it shall take and who shall control it.

Who Will Have Control?

The local authorities desire complete control of the hospital services in their own areas, a point of view supported by the terms of the Public Health Act, 1936. They want all

funds provided by the state for health services to be handed to them for distribution. If this were done it would leave them in virtual control of the voluntary hospitals. The voluntary hospitals have already reached a stage at which only a comparatively small proportion of their income is received from voluntary subscriptions and donations, while considerable sums are provided by the state, local authorities and patients (this last mainly through contributory schemes). This state of affairs has been aggravated by the war, and the tendency is likely in time to become even more exaggerated.

Voluntary Hospitals Resist

The voluntary hospitals are resisting pressure to bring them under the sway of the local authorities. There is reason to believe that they would welcome a national hospital board on which they and the local authorities and the Ministry would be represented by specially qualified people. Through this board grants would be made direct to voluntary hospitals throughout the country. This would give the voluntary hospitals a measure of independence in their dealings with the local authorities.

The hospitals recognize that if either the state or local authorities, or both, claim direct representation on their governing bodies proportionate to the funds the voluntary hospitals receive from these sources it will mean that the virtual control of these hospitals will pass either to the state or to the local authorities or to the two of them jointly.

A great many of the voluntary

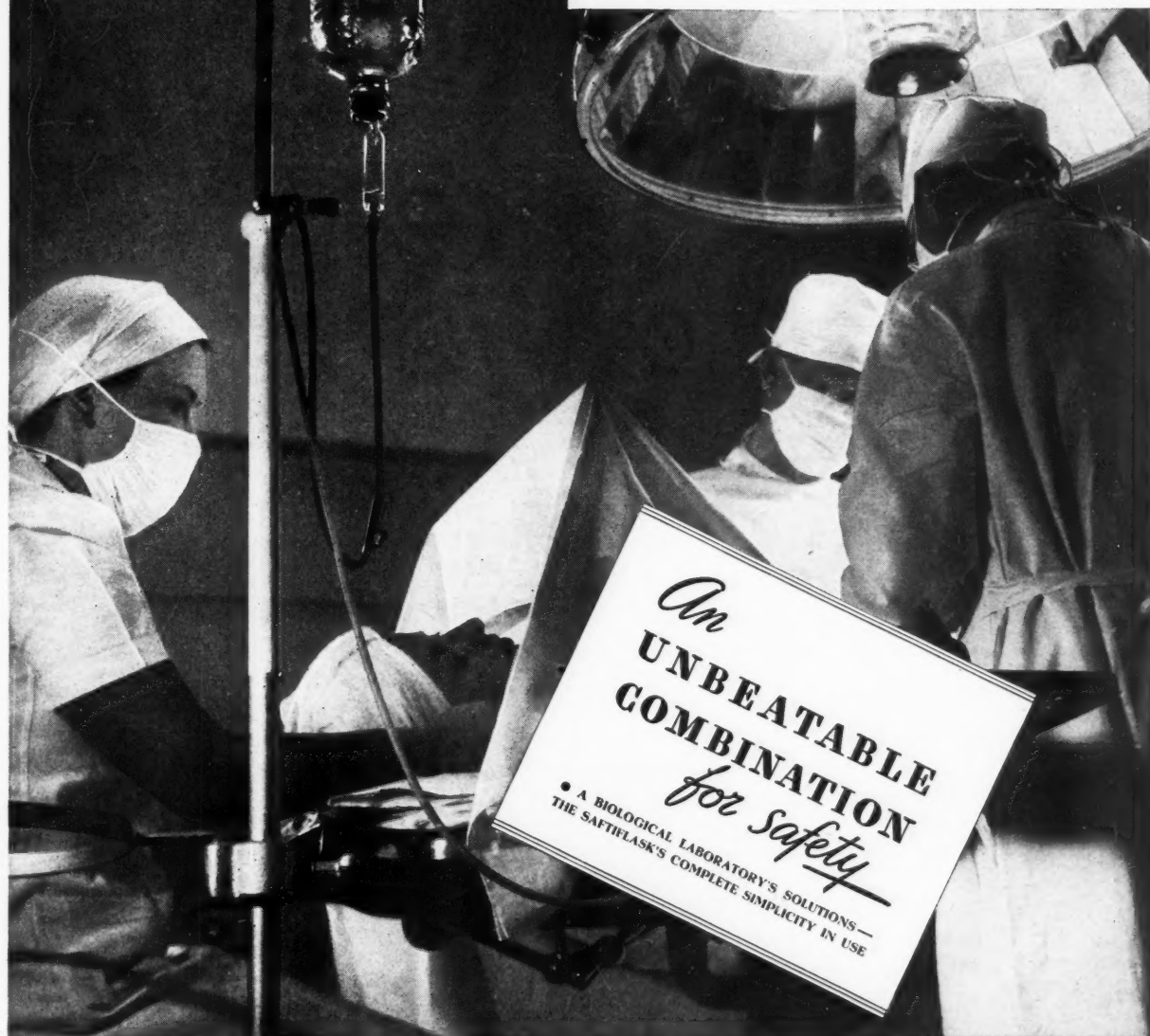
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hospitals would probably desire to see the continuance of the contributory schemes as a method of financing patients' payments for hospital services. These schemes are mainly directed toward the support of the voluntary hospitals and they and their medical staffs generally have the majority representation on the governing bodies of the schemes, even when they are not organized directly by a single voluntary hospital.

Payments by the schemes are made on a more generous scale to the voluntary hospitals than to the public authority institutions. The reason for this appears to be that the schemes were primarily brought into existence not for the insurance of the patients but for the support of the voluntary hospitals.

This orientation will undoubtedly disappear if the schemes are to be allowed to continue, for the local authorities are likely to demand equality of payment with the voluntary hospitals in respect to contributory scheme patients. This in itself would weaken the interest of the voluntary hospitals in the continuance of the schemes although they would probably regret their extinction.

The contributors to the schemes are not generally represented on the hospital boards and therefore the hospitals receive substantial financial support without the necessity of conceding equivalent representation. Thus, the governing bodies of the voluntary hospitals would seemingly prefer to have the support of the contributory schemes rather than the aid of state contributions only.

If the Beveridge plan is adopted and workers are called on to make a

payment thereunder of 4s.2d. per week (approximately \$1) they probably will not be willing to pay, say, 6d. (12 cents) a week for hospital services but will expect one contribution to cover everything; nor is the attitude unreasonable. It is doubtless because they recognize the possibility of the extinction of the contributory schemes that the voluntary hospital interests are anxious that a national hospital board should be set up.

The voluntary hospitals are likely to find support from the medical profession as represented by the British Medical Association because, for the senior staff, service in the voluntary hospital, even where there is remuneration, is on a part-time basis and leaves ample opportunity for private practice, whereas it must serve full time in the hospitals administered by the state and local authorities. Also, in the voluntary hospitals, the senior medical staffs have a considerable degree of both individual and corporate freedom, being represented sometimes directly on the hospital board by some of their number or more often by a medical committee that has access to the board.

In most public authority hospitals, since all medical staff members are salaried full-time officials, they are supervised by and are under the instructions of the medical superintendent who, in turn, is answerable to the medical officer of health for the district.

In their case for maintaining their freedom from national and local governmental control, the voluntary hospitals claim a considerable degree of superiority over those hospitals controlled by public authorities, a superiority that they affirm is due to

their organization. There is much to be said for this point of view as regards the organization of medical staff, but the superiority could probably truthfully be claimed only for a few of the large and outstanding voluntary hospitals. Some of the small voluntary hospitals do not render nearly as satisfactory service as the better local authority institutions.

The local authorities undoubtedly have an answer to the claim of the voluntary hospitals. The public authority hospitals have only grown up since the passing of the Local Government Act in 1929 (as extended by the Public Health Act 1936) and already many of them have made tremendous strides. In some cases their work approaches that done in the best voluntary hospitals and far surpasses the work done in the worst. Given a few more years there will undoubtedly be further improvements.

The chief handicap under which the newer hospitals labor is that only one of them is at present recognized as a medical school. If the outstanding institutions were given that privilege and the staff, although whole time, was organized on the same basis as the staff of the voluntary hospitals, the local authorities might then claim that they were not inferior to the best voluntary hospitals, a claim that would probably be difficult to refute.

There is a third possibility, *i.e.* the organization of the whole of the hospital service for the country direct from the Ministry of Health, presumably with the aid of advisory committees. This is a solution that is hardly likely to be adopted, as it would be unpalatable alike to the voluntary hospitals and to the local authorities.

Whilst I cannot prophesy the outcome of the consultations now going on, I expect that some kind of compromise is likely to be reached that will neither be completely based on the principle of payment of grants through local authorities nor be entirely bound up with the establishment of a national hospitals board. It is difficult to see yet what form such compromise could take, but I would venture a prophecy that sooner or later, probably quite soon after the close of the war, the hospital contributory schemes will cease to exist.

WRITE FOR YOUR VOLUME INDEX

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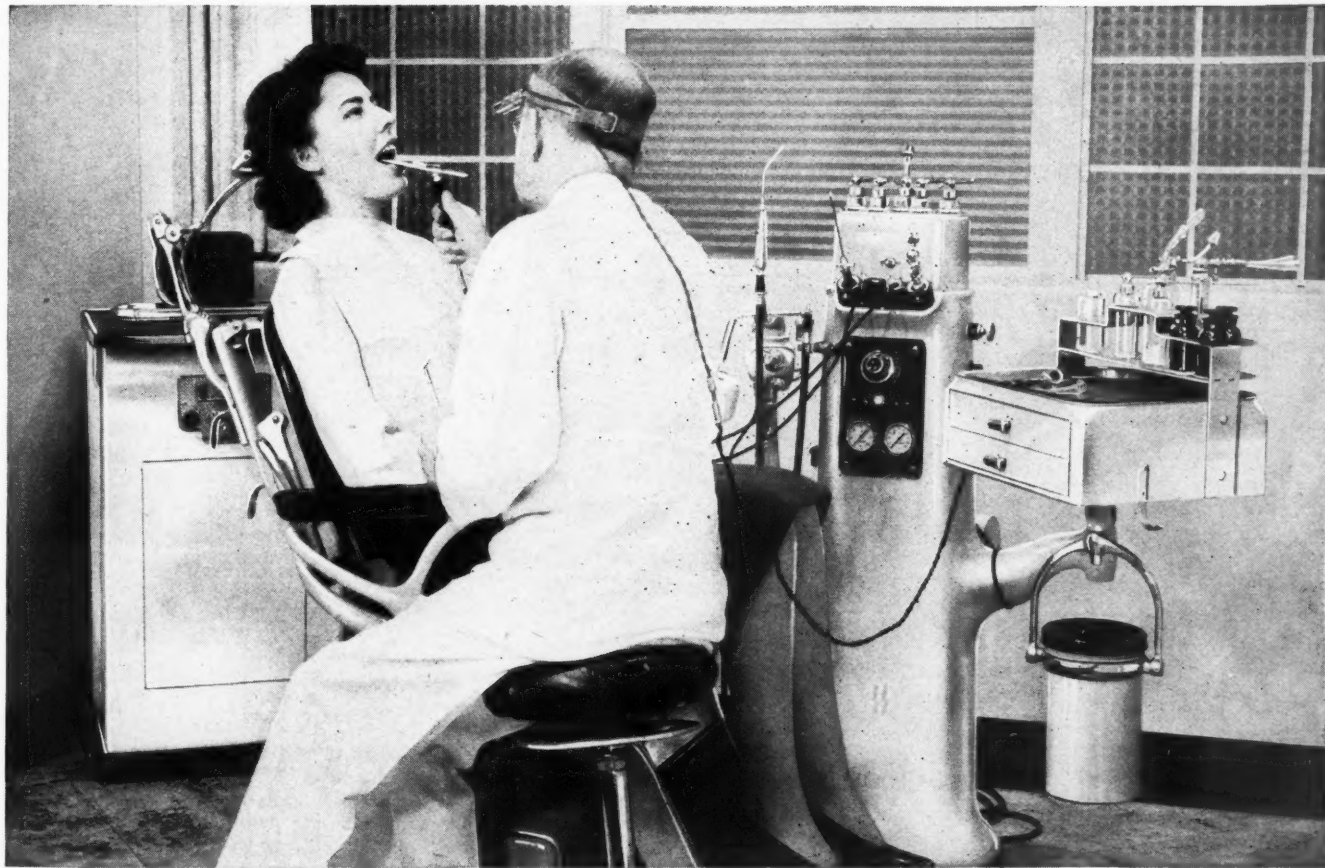
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TRUSTEE FORUM

CONDUCTED BY RAYMOND P. SLOAN

Tests of Trusteeship

ISAAC F. MARCOSSON

THERE are 2926 voluntary hospitals in the United States. Over their destinies preside approximately 60,000 trustees. On these trustees rests a two-fold obligation. They are the keepers, so to speak, of the welfare of their patients, and through the constant shift of patients they touch the well-being of the communities they serve. They are also the stewards of the finances of the institutions.

Trustees shape policy and approve the appointment of directors, superintendents and the medical, technical and nursing staffs. They sponsor significant research and provide invaluable facilities for the training of surgeons and physicians. Upon the ability, judgment and experience of trustees, therefore, reposes responsibility for the lives and futures of many thousands of persons. Thus, hospital trustees, to a large degree, are custodians of the greatest of our national assets, which is health.

At a time when the future of voluntary hospitals seems precarious it may be well to make some appraisal of the equipment of the average trustee. What follows implies no criticism of that large and devoted body of men and women who strive so unselfishly to carry on the executive direction of voluntary hospitals. The sole objective here is to try to set up a standard of efficiency—a blueprint, as it were—that may perhaps enable trustees to do their jobs with a greater sense of satisfaction to themselves and with a higher degree of service to their institutions.

We might start with a comparison, projected to emphasize a basic factor in the making of a trustee.

Back in the days when Wall Street ruled the American financial domain without statutory hindrance of any kind, the directors of most of the great industrial and financial institutions were largely chosen not because of special fitness or intimate knowledge of the enterprises but

Mr. Marcossan, well-known writer, has been vitally interested in hospitals for many years and active on the board of a large New York institution. In this article he defines trusteeship as he sees it with the implications it holds for American philanthropy in the period following the war.

because they were big stockholders or had valuable connections. There were able men on these boards. They often included giants of finance and industry.

The general run of directors, however, were content to attend meetings as a sort of perfunctory service, accepting the usual fee of a \$20 gold piece as part of an easy routine. They were, in the main, a prize lot of "yes men," who adopted reports and endorsed policy, seldom delving into the operations of the bank or corporation. Their knowledge of what was going on was obtained vicariously. They were, in short, directors who did not direct. In consequence, a relatively few men—Titans all—were the arbiters of our corporate life.

That glittering epoch has gone along with the \$20 gold piece. Today the boards of great banks and corporations are composed of competent men, who, by sound qualifications, are watchdogs of company interests. They have a sense of personal responsibility to the stockholders whose trustees they are. They are directors who direct.

The application of these qualifications to the voluntary hospital trustee is obvious. Where the corporation operates to make profit for its stockholders, the voluntary hospital

functions to produce dividends of health for its patients. The measure of efficiency required of company directors and hospital trustees to attain the highest results is the same.

There is another parallel that touches the core of hospital efficiency. In an industrial corporation the plant manager or chief administrator holds his post because he is competent. He is vested with full responsibility and stands or falls by it. Directors do not intrude upon his work.

The same code should apply to the hospital administrator, who, in the great majority of voluntary hospitals, is the principal executive. Like the industrial plant manager he should have freedom from trustee interference so long as he makes good on his job.

Not long ago the superintendent of a small New England hospital was offered the superintendency of a larger hospital in a near-by city. He sought information about the institution that had made him the offer from a friend who was also a hospital executive. The friend told him, "Do not take the post if you value your peace of mind and want to call your soul your own. That hospital is trustee-ridden."

The moral is that there is a big difference between constructive trustee interest and captious trustee interference. One makes for real cooperation; the other for confusion and often worse.

The fact that a man or woman is a large donor to a hospital does not necessarily mean that he is equipped to be a competent trustee. His interest and generosity are commendable but they must be reenforced by familiarity with every detail of the hospital if he is to serve on the board. Hence big gifts, if the donors are trustees, must march with service based on understanding of hospital needs and conditions.

At the root of the trustee's fitness for his post, therefore, lies knowledge of what is going on in his hospital and, incidentally, what is happening in other voluntary hospitals. Attending board meetings and being cognizant of the institution's balance sheet are only part of the equipment. The trustee who realizes his full obligation goes through the hospital at regular intervals, talks with the director or superintendent, dietitians, nurses and doctors. In this way he gets the feel of the place and thus

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can more readily respond to its demands.

This does not mean that the conscientious trustee should make raids on departments to try to "get" something on employes. When trustees make their inspections they should be accompanied by the superintendent or some other member of the staff. Only such visitations can inspire the spirit of cooperation.

The trustee will also find it helpful to visit other hospitals. Thus, he can widen his horizon and enhance his usefulness in many ways.

Knowledge of a hospital, however, is not enough. There must be the will to serve, with a background of initiative, experience and intelligence. The executive direction of a hospital demands zeal, broad outlook and—what is vital—continuing interest.

Cooperation Comes First

One of the first attributes of the trustee is a sense of unselfish cooperation. Architects, bankers, business executives and publicists are valuable assets to any board but their technical or professional experience is more or less nullified if they lack the inclination to study and meet health problems. The trustee should be familiar with the health problems of the community his hospital serves. He should read at least one magazine devoted to hospitals. There are admirable publications in this field that will inform him on progress in hospital methods and management.

Over-individualism in a board is not an asset. It often results from the over-individualism of the trustee. Our rugged American individualism is a valued national heritage but there are times when it must subordinate itself to the bigger good in the shape of teamwork to bring about the best results.

Full mate of the superindividualist is the trustee who regards the hospital as a hobby. Sometimes he rides the hobby so hard that objectives are lost in the gallop. A hospital can be no one man's hobby any more than it can be the proving ground for whim and caprice.

Then, too, there is the type of trustee who regards the hospital as a personal possession. He refers to the institution as "my hospital" in the same way that the late Theodore Roosevelt, when President, often alluded to our armed forces as "My Army" and "My Navy." Such ma-

terial benefactions as he bestows upon the institution are not matched by the obligation of service that true trusteeship demands.

These types of trustees are the exceptions, fortunately. The vast majority of men and women on voluntary hospital boards exemplify the true tradition of disinterested service. They are animated by the same devotion that has made the Red Cross the symbol of a heroic mercy.

The question naturally arises: Why not organized training for trustees? It may seem far-fetched but it is not altogether fantastic. We live in an age of specialization, whether in business or professional life. We train physicians, surgeons, technicians, nurses and superintendents. Trustees wield authority over them. Perhaps the establishment of a technic for trustees might serve a useful purpose.

More and more the conduct of hospitals is becoming a science. Increasing problems in food and other supplies, expanded overhead, difficulty in replacing personnel and all the other war-time distractions that beset and harass large institutions create the demand for highly trained executive direction.

Recognizing these emergencies, the University of Chicago has instituted a course in hospital administration. Throughout the country institutes in hospital administration are held at regular intervals. While these are primarily for men and women who already are, or seek to be, superintendents, some similar plan might well be adapted to trustees.

This does not mean that we would develop professional trustees. Nothing could be more detrimental to the true spirit of the voluntary hospital cause. What it would do would be to raise the standards of trusteeship. John D. Rockefeller and Andrew Carnegie made philanthropy an avocation. Trained men and women translate their benevolence into terms of better health and education the world over.

One delicate problem faces hospital boards. Shall boards be self-perpetuating? There are two sides, of course, to the question. Many men grow old in trustee service but age does not seem to impair their alertness or usefulness. Some 70 year olds on boards serve more effectively than colleagues much their junior in years.

To them the hospital is not only a ritual and a service but something of a passion as well. The dead wood in hospital boards is not always the older men.

On the other hand, the feeling that once a trustee always a trustee makes for slackness. There should be a definite requirement not only in regular attendance at board meetings but in live service as well. If a trustee does not measure up to the standard set by efficient trustees, he should be supplanted. More than once the suggestion has been made for a three year tenure of office for trustees. If the trustee makes good during this time he can be reelected. Such a procedure would put trustees on their mettle.

Linked with the merit system is another debatable question, the establishment of a retirement age. The Rockefeller Foundation, bulwark of so many hospitals, retires its trustees when they reach the age of 65, regardless of their status on the board. John D. Rockefeller Jr. was one of the first to acquiesce to the retirement mandate.

What Can We Do About It?

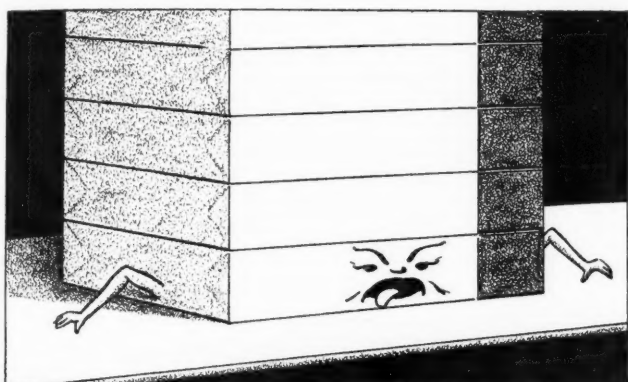
The postwar readjustment period with its immense social and economic changes will inevitably bring about some shift in medical administration. More or less radical ideas, like the socialization of medicine with its prepayment and other features that threaten the old orthodox order, are already at work. Nationalization of voluntary hospitals looms over the horizon. It implies that voluntary hospitals may be approaching the crossroads of their destiny. The supreme problem that faces them in a changing world is the likelihood of governmental assumption of their services. That this would mean an irreparable loss goes without saying. What can be done to circumvent what we all agree would be a major disaster?

There is but one answer. It is up to the trustees to meet the challenge with an even greater efficiency of service than exists today. They can make their hospitals so competent that the government cannot, and will not, take them over. To do this each hospital must cooperate in what has been well termed, "a rounded, over-all program," which means a larger communal service. In this unity of effort lies survival.

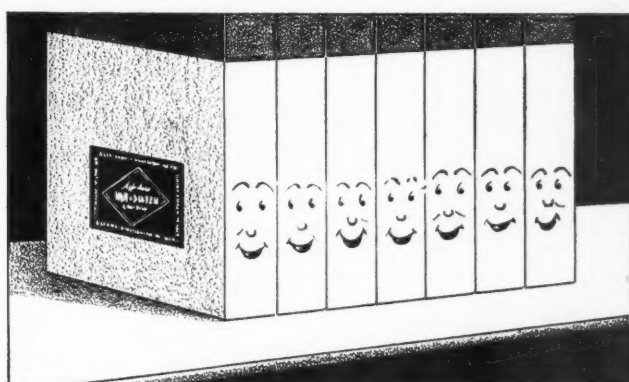
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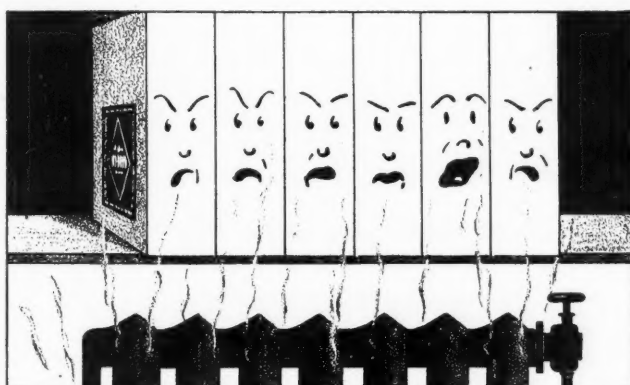
ments like this one, to help you get perfect radiographs by showing *what* influences x-ray film and *how*.



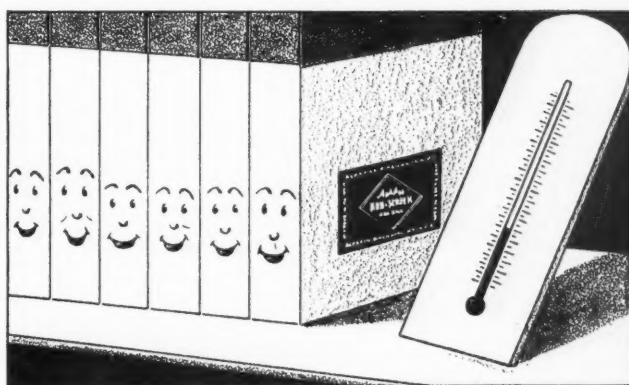
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O. C. D. Helps Hospitals FIGHT FIRE

AMERICA has been at war a year and a half. In that period the consequences of fire have grown until they have become not alone the destruction of life and property but a real danger to the nation's war effort. Equipment damaged by fire may be irreplaceable; man hours lost because of fire are man hours gained by the enemy.

Fire in our war plants, in our schools, in our hospitals or in our homes is as real a menace to the winning of this war as is a saboteur, an enemy agent intent on destroying this country from within. It is imperative that we prevent fires and are prepared to fight fires, whether they are caused by carelessness or by enemy incendiary bombs. It is particularly important that such vital institutions as hospitals be so prepared.

O.C.D. Trains Fire Guards

The Office of Civilian Defense, charged with the protection of civilian life and property from the effects of enemy action, is setting up the "fire guards," a group of volunteers who will learn the use of the hand fire equipment now available, will be instructed in the hazards of explosive incendiaries and will be able to handle them without delay. War's special hazard is the possibility of air raids, incendiary bombs and the resulting fires. The fire guards are the nation's answer to this threat.

A fire guard's duties are vital to the protection of his sector. As applied to the hospital, they include the following:

1. Organization of all sector first-aid fire-fighting activities in the hospital.
2. Instruction of hospital personnel in fire defense.
3. Instruction of hospital personnel in the cautions to be observed in

L. W. HUTCHINS

Chief, Fire Defense Education
Office of Civilian Defense
Washington, D. C.

connection with incendiary bombs and methods of attacking them.

4. Mobilization of fire-fighting equipment.

5. Reduction of fire hazards within the hospital.

6. Location and manning of lookout posts to observe the fall of incendiary bombs.

7. The handling of incendiary bombs and the fires resulting from them.

8. The extinguishing of small fires from ordinary causes.

9. The summoning of assistance from regular and auxiliary fire-fighting forces during air raids.

10. The guiding and furnishing of information to regular and auxiliary fire-fighting forces as requested.

11. The making of reports concerning fires and fire defense.

The fire guards' insignia is that which formerly represented the fire watchers (now absorbed in the fire guard), *i.e.* the usual white equilateral triangle superimposed on a circular field of blue, enclosing a red flame.

Each hospital, under the guidance of its local civilian defense council, should organize its fire fighters into a fire guard unit as the most effective way of protecting itself against fires caused not only by enemy air action but by ordinary causes. A fire brigade leader—possibly the hospital's chief engineer—should be responsible for the training and activities of the hospital's fire-fighting force.

The leader supervises the fire and air raid alarm systems, locates fire protection equipment properly and assigns fire guards to their duties.

He establishes fire lookout posts so that all sections of the hospital will be under observation during an air raid.

An important feature of each hospital's fire guard activity will be the prevention of fire. Just as increased emphasis should be placed on training so, too, fire prevention measures must be more rigidly exercised and enforced. Careless smoking in the hospital should be discouraged and in some areas smoking should be forbidden. Regular inspection of attics, basements, wards and storage spaces should be made.

Hospital records, necessary and valuable, are also flammable and should be kept in fire-retarding cabinets or vaults, as should x-ray films. Records and films that are no longer needed should be destroyed. Every precaution against fire must be taken. America's hospitals are too busy in the precious business of saving life to allow fire to claim a toll in time or equipment or of life itself.

Guards Are Not Auxiliary Firemen

Fire guards—whether they are in a hospital or a neighborhood—should not be confused with auxiliary firemen. Fire guards are trained to know structural conditions in a particular area and how to use hand fire equipment in controlling bombs and small fires. Auxiliary firemen are trained to work with professional firemen in controlling large blazes to prevent them from reaching conflagration proportions.

The Office of Civilian Defense bulletin, "Protection of Hospitals," which was published in full in the February 1942 issue of *The MODERN HOSPITAL*, still gives a fairly complete picture of the means of protecting a hospital from possible enemy action. A few of the points, however, might well be reiterated

HOFFMAN EQUIPMENT HAS GONE TO WAR

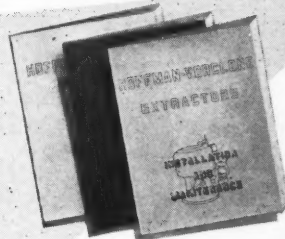
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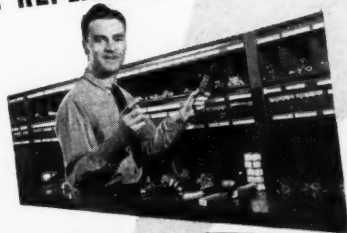
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and the hospital fire brigade leader will quite naturally see that they are brought home to his fire guards.

Today it is more important than ever before that every hospital, large or small, is adequately equipped, that its fire fighting personnel is thoroughly trained.

Air raids require a different procedure than do ordinary fires. When a fire alarm sounds, fire guards proceed directly to the location indicated by the alarm, pausing only to take along with them whatever equipment has been provided, such as a cart equipped with extra fire extinguishers and special tools for fighting fire.

When an air raid alarm sounds, the fire guards assigned to lookout duty go at once to their posts. For the others, the alarm is in the nature of an alert and they go on about their regular duties until the lookouts summon them to assembly points where they stand by for duty as they are needed.

These assembly points should be equipped with fire extinguishers and other appliances that fire guards will carry into their attack on fire bombs and any resulting fires.

The turnover in hospital personnel makes it necessary to hold monthly drills to train new employees. Monthly inspection of all fire-fighting equipment is necessary to keep it ready for use in the instant it is needed.

In the event of fire, the first responsibility of nurses and orderlies lies with their patients. But even though they should not be counted on as a fire-fighting staff their help may be necessary in an emergency, so they should be trained in the use of simple fire-fighting equipment.

The protection of hospitals from enemy action—the removal of glass windows, the shoring up of walls or the building of raid shelters—is a matter for the individual hospital which will undoubtedly work in conjunction with its local civilian defense office in deciding how best to prepare itself. Action that may seem necessary to some hospitals in the coastal areas may be unnecessary for inland hospitals or for hospitals that by the very nature of their construction are already well prepared to withstand bombings.

Just as medical problems must be decided within the individual hospital, so the problems of protection

from fire and bombs must be worked out by the men and women who best know and understand the particular problems of a particular institution. And just as surgery and neurology and pediatrics are highly specialized fields, so the fighting of fires should be primarily the duty of those who

have been well trained in that field.

A hospital's fire guard must be constantly on the alert against careless fires and constantly braced to meet the possible impact of enemy air action. When a trained force is so prepared, fire loses much of its power to destroy.

Engineers' Question Box

Gas Supply Ample

Question 27: What effect will the war have on the use of gas and oil in hospital heating plants in the coastal regions?—R.S.T., N. Y.

ANSWER: Oil, of course, is severely restricted on the Atlantic seaboard. Gas for heating and for other purposes is produced either in coke ovens as a by-product in making coke or from gas wells located in many states where oil is found.

The war has increased gas production from coke ovens. In fact, because of the increased demand in the iron smelting industry, more coke ovens are fired now than during peace time and, consequently, more gas is produced.

The oil fields produce more gas than we can use for years to come. Pipe lines are being extended to bring this gas to far-flung parts of our country. There is no cause for hospitals to worry about shortage of gas, if such gas comes from the oil fields or coke ovens serving the steel and iron industry.—E. W. RIESBECK, consulting and construction engineer, Chicago.

Best Temperature and Humidity

Question 29: What are the best temperature and humidity to maintain in an air-conditioned operating room? In an air-conditioned nursery?—W.F.A., N. J.

ANSWER: The best temperature for an air-conditioned operating room, according to most authorities, is 80° F. The relative humidity should be from 55 to 60 per cent. In actual practice it will be found that the temperature is dropped to between 72 and 76° F. with a relative humidity of 55 per cent. The reason for the lower temperature is that the operating surgeon and personnel are more comfortable. The 80° F. temperature is fine for the patient but is too warm for everyone else.

The fact that the patient can be covered and that hot water bottles can be used to maintain the proper temperature and to prevent shock makes it possible to use the lower temperature without in any way endangering the patient.

In the nursery, a temperature of 80° F. with a relative humidity of from 60 to 80 per cent is usually recommended. This is uncomfortable for the nurse, but, owing to the fact that the heat regulating system of the baby's body is not fully developed, it is necessary to maintain this temperature and humidity.—LELAND J. MAMER, Evanston Hospital, Evanston, Ill.

Do Heat Reclaimers Save Money?

Question 31: Can we save money by using heat reclaimers in the discharge water from our washers in the laundry?—F.B., Ill.

ANSWER: This is a debatable question as the size of the laundry and the amount of waste exhaust steam must both be taken into consideration.

There is an expensive heat reclaimer built for just such a use, but I do not believe it has been proved successful except in large commercial laundries. If your laundry employs a steam engine for power and you have other steam auxiliary equipment in your plant, you no doubt have plenty of exhaust steam that otherwise would be wasted to the atmosphere if you used a heat reclaimer.

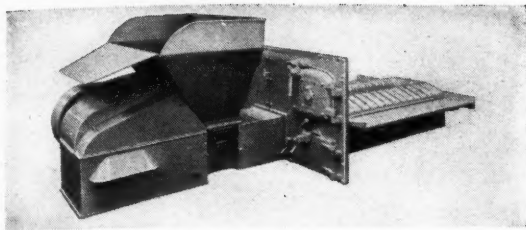
If the plant is electrified and steam is used only on ironers, pressers and tumblers and you have motor driven pumps and other auxiliaries, then a heat reclaimer would be justified. With the use of copper pipe and sweat fittings and a little ingenuity the engineer can build his own heat reclaimers.—LELAND J. MAMER, Evanston Hospital, Evanston, Ill.

Pulverizer v. Stoker

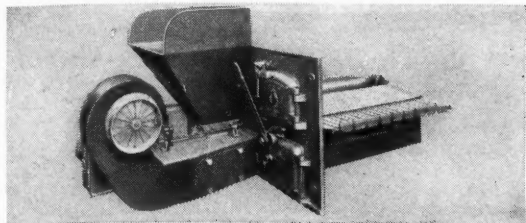
Question 34: Our hospital has been heating with oil and we expect to change over to coal. Would we do better to use a stoker or a pulverizer?—R.S., Ind.

ANSWER: Whether a pulverizer or a new type of stoker should be installed depends upon the following factors:

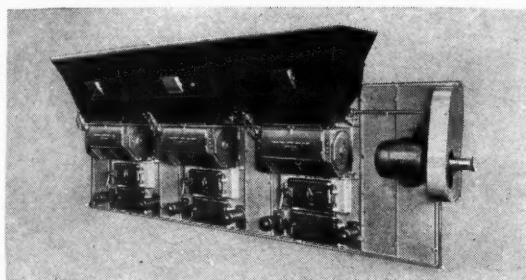
1. The proximity of the hospital to the source of the coal supply and the type of coal mined by this source of supply. The distance from the mine,



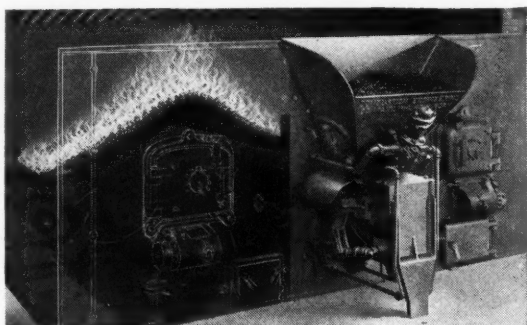
C-E SKELLY STOKER



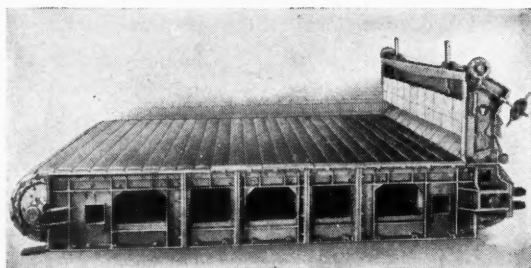
C-E LOW RAM STOKER



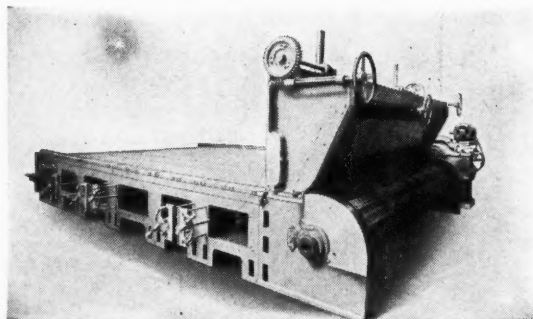
C-E SPREADER STOKER



C-E TYPE E STOKER



C-E TRAVELING GRATE STOKER



C-E CHAIN GRATE STOKER

IF YOU'RE THINKING OF CONVERTING TO COAL

...better do it now!

Make no mistake about it, conversion from oil to coal firing is going to continue. The reasons are just as compelling today as they were a year ago. Right now there's barely enough time left to convert before the late Fall heating load will increase fuel consumption. Those who act promptly will be ready. Those who don't will find themselves facing delayed deliveries of equipment.

CONVERSION MEANS SAVING

Fortunately, converting to coal isn't just a nuisance and an expense. In fact, for those people who obtain the right kind of installation it can prove a blessing in disguise. Besides avoiding interruptions of vital heat and power service, coal firing is more economical in the long run. Hence the right conversion job can be a source of saving not only during the present emergency but long after the war is over.

HOW TO GET A GOOD CONVERSION JOB

To be sure of getting a good conversion job, let Combustion Engineering survey your plant and make a recommendation. From the C-E line of stokers — the most extensive on the market — you will be sure of getting the right type of installation for your needs — and you will get the benefits of nearly half a century of experience in the stoker field, plus the "know-how" acquired from many hundreds of conversion jobs completed within the past year.

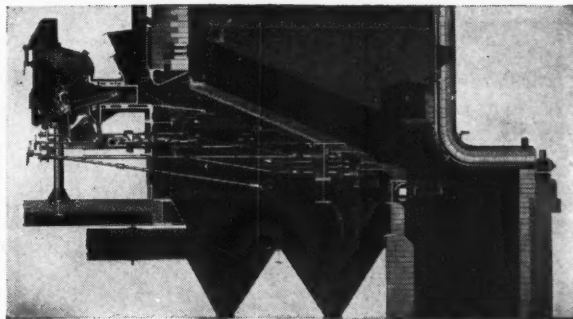
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Yugoslav destructive raids across borders of Italy and Bulgaria, according to reports received in London. (2:2)

the mine sinking one. (1:3)

HOSPITAL NOISE DEMONS KILLED IN ACTION

Thousands Trapped in Cushiontone ceiling! Smothered instantly

Sudden death came to uncounted thousands of unsuspecting noise demons last night, in what is unquestionably the most enormous in the annals of demon history. Intent merely on the

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CORRIDORS, kitchens, visitors—all produce noise demons to pound the eardrums of staff and patients, reducing staff efficiency, retarding recovery of patients.

But there is an efficient noise demon exterminator. A ceiling of Armstrong's Cushiontone smothers up to 75% of the noise that reaches it, thanks to the 484 deep, sound-absorbing holes in every 12" x 12" unit. Repainting (even with ordinary paint and painting methods) does not affect this permanent high efficiency in the least.

This remedy for noisy hospitals is surprisingly low in cost. A ceiling of Cushiontone is quickly installed with little or no interruption to hos-

pital routine. Maintenance is no problem at all.

Cushiontone offers other advantages, too. Its high light-reflecting efficiency (73%) provides better illumination. Its high insulating properties save heating and air-conditioning costs. And all the time it's doing its job of quieting unwanted noise.

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affecting transportation cost, may not justify the mine operators in selling the fine coal at a sufficiently reduced rate to make it more economical to burn than the stoker coal.

2. The cost of the mine-run coal for the pulverizer as compared with that of the "bug dust" type of fuel that might be used in the pulverizer.

3. The supply of coal available. If there are many pulverizers in the locality, causing competitive bidding for this type of fuel, it would not be profitable to burn it, because the pulverizer's greatest economy lies in its ability to utilize a cheap, finer type of coal. If coarse coal has to be used in the pulverizer the cost of pulverizing it would make it more costly to burn than the stoker coal.—E. C. FRANCON, *chief engineer, St. Luke's Hospital, Denver.*

How to Prevent Fly Ash

Question 35: If we install a pulverizer under our boilers, how can we avoid complaints about fly ash?—R.S., Ind.

ANSWER: The ideal condition to eliminate fly ash would be to have a fairly long breeching connected high to a tall stack of large diameter. We have had no complaints from anyone in our neighborhood regarding the fly ash. In the hospital we have noticed that the walls collect a film of dust more quickly than they did before we installed a pulverizer. We attribute this to the powdered coal used and perhaps somewhat to the fly ash.—E. C. FRANCON, *chief engineer, St. Luke's Hospital, Denver.*

\$5 AWARD TO OLSON

His comprehensive answer to a question on how to lengthen the life of rubber belts on hospital machinery won the June award for Oscar E. Olson, chief engineer of Wisconsin General Hospital, Madison.

Ideal Temperatures

Question 29: What are the best temperatures and humidity to maintain in the air-conditioned operating room? In an air-conditioned nursery?—W.F.S., N.J.

ANSWER: Operating rooms *must at all times* maintain a relative humidity of from 50 to 55 per cent and a temperature of from 74 to 76° F. whether they are air conditioned or not.

The proper temperature in a nursery ranges from 76 to 80° F. with a relative humidity of from 50 to 55 per cent except for premature births, which must be kept in a separate room where the temperature is not less than 80° F. and the humidity is between 52 and 55 per cent.—E. W. RIESBECK, *consulting and construction engineer, Chicago.*



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by good care ... Conserve fuel by promptly
replacing worn-out or inoperative parts.

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Troubles often begin with failure to observe recommended working pressures.

Your steam heating system is worth protecting. Excessive pressures caused by careless boiler firing, incorrectly adjusted or inoperative reducing valves, etc., may cost you money in time, labor and materials. Damaged equipment may be irreplaceable and when it can be replaced uses metal essential in the war effort.

The life of your thermostatic traps and their ability to use steam efficiently depends on proper control of working pressures. Keep working pressures within the limit recommended by the manufacturer.*

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Webster Representatives in principal cities are trained heating specialists whose services are available to help you keep your heating system in first class operating condition. Consult your phone book. Write for booklet, "How Much Steam Waste in Your Heating System".

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*Recommended operating range for Webster Thermostatic Traps is as follows: Sylphon and Series 7 Traps, up to 5 lbs.; Series 7M Trap, up to 15 lbs.; Series 78 Trap, Cl. 2, 15 to 60 lbs.; Series 78 Trap, Cl. 3, 60 to 150 lbs.

Illustrated at right is the Webster "Old Ironsides" war-time radiator trap.



HOUSEKEEPING PROCEDURES

Conducted by Alta M. LaBelle

Remedying the Manpower Headache

We can talk ourselves blue in the face about the advantages we can offer our employees—stability of employment and the hospital care that they can expect in the event of illness, but it all becomes too insignificant when compared with the present high wages in industry, and it is mighty difficult to steer the thoughts of

housekeeping employees, particularly to the future when the present is so difficult and the future so uncertain.

These are some of the problems that are now confronting all of us. But we are all familiar with the questions. What about the answers?

It seems to me that our salvation dur-

ing the difficult days to come will lie in making the best possible use of the personnel we have; in streamlining our procedures, and in "selling" the housekeeping department to our employees by improving working conditions, increasing wages and eliminating insofar as possible the drudgery that is, unfortunately, too closely associated with the word "housekeeping."

Let us consider some of the steps that must be taken:

1. We must analyze and reanalyze, not once, but again and again, our job breakdowns and lines of demarcation.

2. We must set aside our single track "blinders" for the duration and become flexible enough to meet changes from day to day to keep up our standards of asepsis and esthetics—or, at least, maintain a reasonable facsimile thereof.

3. We must weight carefully what jobs may be considered "frills." Many frills will have to be discarded for the duration and many may have to be only somewhat curtailed. We have become so accustomed to accepting frills as necessities that it is hard to discern which is a frill and which is a necessity.

4. We shall have to provide more supervision despite the decreased number of domestic personnel—this because of the rapid turnover.

5. We must pay increased wages and, perhaps, even offer bonuses for stability and reliability even though a job may still not come up to par, granting that we are fortunate enough to obtain even those employees from the "bottom of the barrel." One Chicago hotel pays \$1 to every employee who brings in a new employee. And if the new employee stays a month, the award is increased to \$5.

A Chicago hospital advertises in many rural newspapers, chiefly the foreign language ones, promising a job to anyone who will apply. While the hospital does not pay the transportation, a representative does meet these applicants at the train. To date, almost every applicant has proved satisfactory. Also, this hospital, which is located in one of Chicago's worst neighborhoods, has acquired some houses adjacent to the hospital, furnished them nicely and is now "rooming" these out-of-town girls, making only a small deduction from their pay for this accommodation.

Many of the hospitals have attempted to employ the handicapped, but with little success.

Some few have resorted to pirating. (But that does not solve a problem, does it?)

6. It seems quite clear that the problems of today's domestic personnel are but a sample of what the postwar domestic problems will present. I believe

Abstract from an address to the American College of Surgeons regional conference, March 1943.

NEW! Rapid Sulfonamides Test Kit

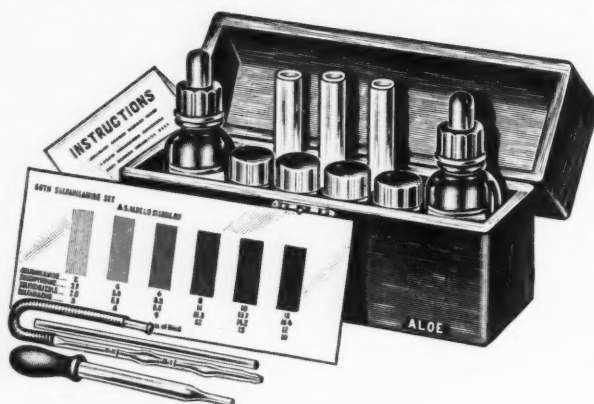
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Reference

A. Goth, "A Simple Clinical Method for Determining Sulfonamides in Blood," *Journal of Laboratory and Clinical Medicine*, Vol. 27, No. 6, March 1942.

Only 7 to 8 Minutes Average Time for a Single Test

The Goth Test Kit includes all necessary reagents and apparatus for the simple and rapid clinical determination of free sulfonamides at the bedside or in the laboratory, including sulfanilamide, sulfapyridine, sulfathiazole, and sulfadiazine. The Goth method has the unique advantage of using tablets containing the correct amounts of reagents mixed with special, selected binders that do not cause cloudiness or turbidity in the diluted specimen. The use of acetone as a protein precipitant eliminates the necessity of filtration.

The method is sufficiently accurate

for clinical determinations. The accuracy of the test is limited only by the visual method of color comparison. If greater accuracy is required and laboratory facilities are available, the reading of the color can be done with a photoelectric colorimeter using an appropriate calibration curve.

L3-780—Goth Sulfonamides Test Kit, size 8½ by 2½ by 4½ inches, complete with sufficient tablet form reagents (except distilled water and acetone) for 100 tests, color chart and directions, each.....\$12.50

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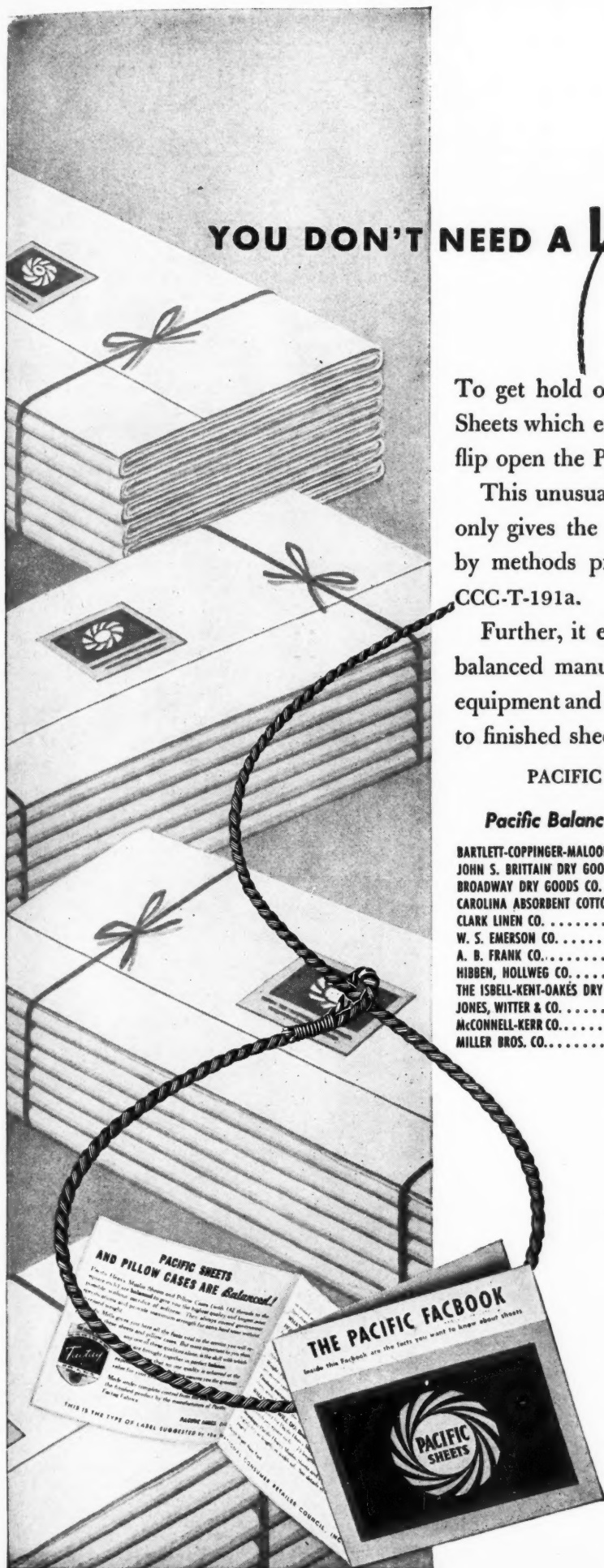
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that our servant or service problems may never return to prewar status. Women will have found their places in industry and domestic work will become more and more distasteful to them—and they have little enough taste for it even now.

The salvation may be in the same sort of glamourization or glorification as has been injected into the nursing profession. Domestic employes must be made to feel that they are important to the care of the patient, even as is the nurse.

Inasmuch as there is little glamour in scrubbing floors on one's hands and knees, for example, our glorification program must entail the inauguration of

modern mechanical methods of cleaning and maintenance and the elimination, especially in new buildings, of such "headaches" as the transportation of refuse, windows that cannot be washed from the inside and other problems that we are finding increasingly difficult to solve because of lack of time and manpower.—ALTA M. LABELLE.

Floor in the Isolation Unit

Some time ago at a New England hospital meeting, the question was asked: "What is the best method, from the standpoints of economy and the elimination of infection, of cleaning linoleum

floors in the patients' rooms in a communicable disease unit?

The answer to this question was presented by Mrs. Lillian Jacques, executive housekeeper at Newton Hospital, Newton Lower Falls, Mass., who first pointed out the hazards to be encountered in the use of vacuum cleaners and dry mops in such a situation.

"The vacuum cleaner is out definitely," she declared, "because of the danger of transmitting the disease to the person who empties the bag or cleans out the can. I think someone should invent some way of destroying the contents of a vacuum bag in such a way that no one has to come into contact with them. I would also eliminate the dry mop unless it can be properly washed and disinfected immediately.

"I am in favor of sweeping the floor carefully with a good corn broom, and I say corn broom instead of a push broom because the former is easier to take care of afterward. Just let it soak for fifteen minutes in good hot soap suds, rinse it and stand it on its handle to dry and you are done with it.

"After sweeping carefully, wash the floor with a solution of neutral soap and hot water. Temperatures higher than 140°F. are considered adequate to destroy all bacteria. Neutral soap has a linseed oil base that puts oil back into the linoleum and most neutral soaps contain pine oil or other disinfectant.

"The germicidal value of soap varies with different organisms. Among those that are affected by soap are the streptococcus, the staphylococcus, the pneumococcus and cholera and diphtheria bacilli. The germicidal action is further supplemented by the sterilizing effect brought about by the mechanical removal of bacteria.

"After the floor has been thoroughly dried it should have two coats of water wax with a good burnishing after each coat. When this has been done no dust will rise when the floor is swept owing to friction which causes the wax to take on an electrically negative charge while dirt, which is carbon and silicate, is electrically positive. Therefore, the dust is pulled down to the waxed surface."

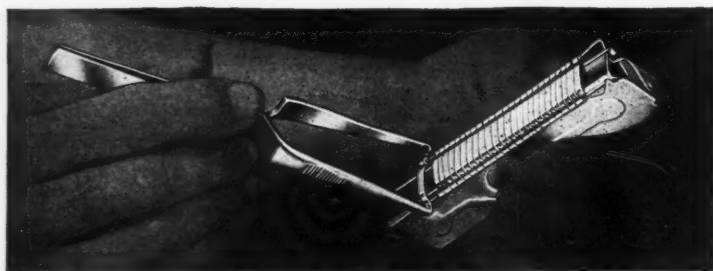
Checking on Completed Work

Records are a nuisance to keep but they undoubtedly have their uses. It is the feeling of Mrs. Winona Ballantyne, executive housekeeper of the State University of Iowa Hospitals, Iowa City, that the housekeeper should keep records of completed work in the department to the extent of being able to give a comprehensive and accurate report of any of the department's activities at any time.

Monthly reports, Mrs. Ballantyne asserts, are informative and stimulating and should be submitted to the administrator at his request.

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The Bowen-Adams Wound Clip Rack should be used only with the improved Hegenbarth-Adams Wound Clip Forceps.



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As an aid in conserving the limited supply of wound clips now available, it has been suggested that a wire of clips of each size that you use be placed each on one of the Bowen-Adams Wound Clip Racks where they are ready for use and protected from damage. The wound clips not used during an operation will remain on the Rack and are ready for use for subsequent operations. In this way, the tendency to discard the unused portion of a Rack of clips is minimized.

B-2339/SS Bowen-Adams Wound Clip Rack made of Stainless Steel. Each.....	\$ 2.00
Dozen	20.00
B-2323/SS New Hegenbarth-Adams Wound Clip Applying Forceps, made of Stainless Steel, self-retaining, clips do not fall out. Each.....	\$ 2.50
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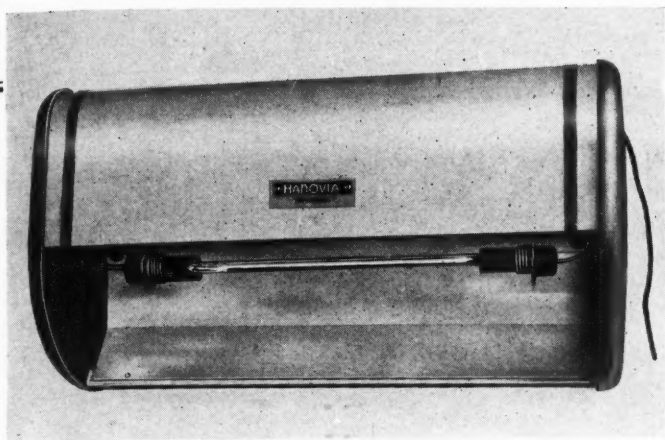
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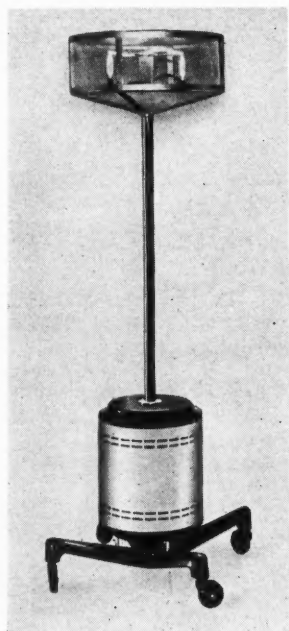
plus increased production enables Hanovia to announce new low prices. Hanovia produces the world's finest quartz ultra-violet lamps for air sanitation, possessed of high efficiency and exceptionally long life.

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Ultra-violet irradiation has proved effective in destroying air-borne droplet nuclei containing pneumococci, hemolytic streptococci, tubercle bacilli, influenza virus type A, and other organisms.

New, improved models now available for operating rooms, clinics, isolation wards, milk formula rooms and nurseries.

Investigate Hanovia Safe-T-Aire protection today! Complete details on request.



Portable model for rapid room disinfection. Vacated rooms can be made ready for incoming patients in about one hour. Of great assistance in overcoming shortage of rooms.



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NEWARK, NEW JERSEY

PEANUTS *in menu planning*

PEANUTS are a concentrated food, low in moisture content and high in fat and protein. The composition varies according to the variety and locality in which the peanuts are grown. The average composition is 4.6 per cent moisture, 2.5 per cent ash, 26.9 per cent protein, 45.6 per cent fat and 20.4 per cent carbohydrate.

The protein content makes the peanut of particular importance in modern diets, especially where a limited amount of meat is available. The value of any food as a source of protein is determined by the number and kind of amino-acids present and by the digestibility of the protein.

Protein Value Demonstrated

Studies by D. Breese Jones of the U. S. Department of Agriculture have shown that the proteins of peanuts are adequate for normal growth and development of experimental animals. Rats that received a diet of bread made from wheat flour (74 per cent extraction) and supplemented with butterfat and minerals grew at about half the normal rate. When this bread was replaced by one made from 25 parts peanut flour and 75 parts wheat flour, normal growth was obtained. The value of peanuts as a sole source of protein and as a supplement to wheat flour has thus been demonstrated.

A similar type of experiment showed that peanut meal could make good the protein deficiencies of cornmeal. Peanuts can be recommended, therefore, as a meat alternate and as a supplement to diets that are predominantly cereal in content. The high fat content gives the peanut a high calorie value.

Peanuts are an important source of the vitamins of the B-complex. There is considerable variation in the values reported in the literature, probably resulting from the differences in samples and source material and also from the differences in methods of vitamin assay.

E. NEIGE TODHUNTER

Head, Department of Nutrition
University of Alabama
University, Ala.

The vitamin content of raw peanuts with the skins removed is as follows: vitamin B₁ or thiamine, 0.9 mg. per hundred grams, riboflavin (or B₂) 0.30 mg., pantothenic acid 3.4 mg. and niacin 13 mg. per hundred grams.

Unfortunately much of the thiamine is destroyed in roasting or blanching nuts so that peanut butter, for example, contains only from one third to one fourth the amount of this vitamin present in the raw product. Improved methods of roasting and preparation should make it possible to supply peanut butters much richer in thiamine than those now available.

Niacin does not appear to be destroyed by roasting. A hundred gram serving (3¼ oz.) of peanuts supplies approximately 72 per cent of the day's requirement (18 mg.) for a moderately active man. Peanuts, consequently, have definite value as a pellagra-preventive article of diet.

The peanut also makes an appreciable contribution to the mineral content of the diet supplying in each hundred grams of nuts, 0.111 gm. calcium, 0.394 gm. phosphorus and 2.2 mg. iron.

Peanuts can be used in a wide variety of ways in planning the day's meals. Steamed or boiled and served with white sauce or chopped and combined with rice or beans and eggs, milk and seasoning to form a loaf, they can be served as a main dish. Chopped peanuts may be combined with cream cheese as a sandwich filling. Chopped nuts also may be used as a garnish for creamed vegetable dishes, for fruit salads and in salad dressing. Chopped and combined with cornbread, fat and seasoning or with potatoes, fat and seasoning these nuts may also be used

as a stuffing for meat and poultry.

Peanut butter is one of the best known and most popular of the peanut products now in use in modern diets. This product was first manufactured in St. Louis in 1890 and has since become one of the most popular sandwich spreads. A recent report showed that peanut butter has from 324 to 450 micrograms of vitamin B₁ (thiamine) per hundred grams, which is about one fourth the day's requirement for an adolescent or a moderately active woman.

Yeast Enriches Peanut Butter

In order further to enrich the content of peanut butter in vitamin B₁, riboflavin and niacin as well as in the other vitamin B factors, pyridoxine (B₆) and pantothenic acid, a special yeasted peanut butter has been prepared. Using 20 parts of a special high vitamin yeast and 80 parts of peanut butter, this product has been successfully used by Dr. Tom Spies in the treatment and prevention of pellagra and associated vitamin deficiencies in his clinic at Hillman Hospital, Birmingham, Ala.

Peanut butter can be used alone or in a variety of ways in sandwiches, such as combining with diced crisp bacon, chopped onion, pickle relish, prunes and lemon juice or marmalade.

With strawberry preserves peanut butter may be used as a dressing for fruit salad. In addition, adding ¼ cup of peanut butter to each ½ cup of oil gives a new flavor to French dressing.

Peanut butter cookies are always popular and peanut butter added to ground dried fruits may be used as a filling for baked apples or as a fruit roll in place of candy. Peanut butter spread between graham crackers or ginger or molasses cookies gives a new flavor as well as added food value.

Peanut oil has been shown to be highly digestible and to resist oxidative rancidity. It has a good flavor,

high stability and a high smoking point, which makes it advantageous as a cooking oil. It has also been shown to be highly satisfactory as a shortening and in salad dressings.

Peanut flour has not appeared to any great extent on the market as yet, because of certain difficulties in the preparation of a palatable product. However, it is now possible to obtain a peanut flour of light color and smooth texture prepared from partially defatted peanuts. Such pea-

nut flour has from 55 to 60 per cent protein of high biological value and is also high in B-vitamins. This flour can be used successfully in the proportions of $\frac{1}{4}$ peanut flour and $\frac{3}{4}$ wheat flour for cakes and bread.

A coarse peanut meal can be prepared by grinding roasted peanuts to be used in soups, gravies, cakes and candies or in place of almond meals in macaroons.

In menu planning today, when many foods are limited in supply,

the nutritive value of each must be carefully considered. With fewer foods available it is difficult to get variety. Peanuts offer an opportunity for introducing variety into meals through their use as a main dish, a garnish for other dishes and a new flavor for soups, salads, cookies and desserts. The comparatively low cost of peanuts and their contribution in protein and B-vitamins also add considerably to their value in modern diets.

Shorten and Season With Peanuts

EXPERIMENTS conducted at the Georgia Experiment Station of the University System of Georgia have revealed that finely ground paste or butter made from half roasted, blanched peanuts (with skins removed) can be successfully used as a substitute for shortening in a wide variety of bakery products. These include loaf bread, gingerbread, biscuits, cornbread, hot cakes, waffles, muffins and pastries.

The amount of paste needed for most products was found to be 2-1/3 times the amount of shortening called for in standard recipes. The total fat content of the breads was increased about 12 per cent, which was needed because some of the fat in the peanut particles was not available for shortening. There was also an increase in the total protein content of the breads, which tended to make them heavier.

Paste made from half roasted peanuts made the products most palatable, while that made from raw peanuts resulted in an undercooked flavor. Products containing paste made from fully roasted peanuts tasted scorched. It was also found that bakery goods containing the most finely ground pastes were the most tender, had the smoothest texture and were most pleasing in appearance.

New recipes are not required in using peanut paste as a substitute for shortening except that 2-1/3 times as much paste is required as the amount of shortening called for in the standard recipe, with some additional liquid. This is illustrated

HELEN H. THOMPSON and J. G. WOODROOF

Georgia Experiment Station
University System of Georgia

in the accompanying recipe for gingerbread.

Gingerbread

- 1 cup sorghum sirup
- $\frac{1}{2}$ cup sour milk
- $\frac{1}{2}$ to $\frac{2}{3}$ cup (4.2 oz.) peanut paste
- $\frac{1}{3}$ cup water
- 1 egg
- 2 cups flour
- $1\frac{1}{2}$ tsp. ginger
- $\frac{1}{2}$ tsp. salt
- 1 tsp. soda

Cream peanut paste with sirup, then egg. Add the dry ingredients sifted together alternately with milk and water. Bake at 365° F. for thirty minutes.

With pastry (pie crust) the same substitution was made in the standard recipe except that 2½ times the shortening equivalent was required and it was slightly less flaky than standard pastry. Good homemade loaf bread and rolls were prepared with the same proportions of paste as that found satisfactory with gingerbread. Peanut bread had a smooth texture with air cells evenly distributed and uniform in size. This bread remained moist longer.

Investigations into the possibilities of peanuts as seasoning for vegetables revealed that 3 ounces of ground, blanched peanuts (with skins removed) were excellent for seasoning a pound (cooked weight) of most vegetables. White vegetables, such as potatoes, lima beans and fresh or dried field peas, were best when boiled directly with the

ground peanuts, which were placed in a small muslin bag.

Green or yellow vegetables were less suitable for cooking directly with peanuts, owing to the appearance of the whitish, milk-like peanut liquor. Since cabbage, asparagus and carrots are commonly served creamed, this objection was overcome by boiling the peanuts separately. The liquor was then thickened and served with the cooked vegetables as a cream sauce.

With other green vegetables it was found practical to boil the ground peanuts, let the liquor cool, then remove the oil from the top and use for seasoning vegetables.

The preparation of peanuts for either seasoning or shortening is simple but must be done carefully.

1. Use any standard variety of fresh peanuts.

2. Shell, removing all foreign matter, including rotten and discolored nuts.

3. Heat nuts to 250°F., with frequent shaking, for ten minutes.

4. Cool peanuts quickly, rub off skins and separate skins in current of air.

5. For shortening, grind peanuts in peanut butter mill as finely as possible, place in cans or jars and store in cool place. For seasoning vegetables, grind in meat chopper, place in cans or jars and store in cool place.

Unless kept under refrigeration, both of these products show signs of rancidity within a month, but under refrigeration they keep for more than six months.

How to Estimate Ration Points

HELP in determining the number of ration points required for therapeutic diets is given in the two accompanying tables which were prepared by the nutrition committee of the clinic section of the Council of Social Agencies, Chicago, and approved by the regional O.P.A. office.

The following basic daily food allowance was used in the calculations for the diabetic, reduction and high iron diets: one pint of milk; one egg; three slices of bread (90 grams); two servings of 3 per cent vegetables (200 grams); one serving of 6 per cent vegetables (100 grams); two

servings of 12 per cent fruits (200 grams), and 4 ounces of meat (120 grams).

This basic diet provides approximately 42 grams of fat daily. Excluding the meat items, it furnishes approximately 38 grams of protein. For the basic high protein, preg-

Table 1.—Guide for Determining Monthly Allowances of Meats, Fats and Processed Fruits and Vegetables for Therapeutic Diets

DIET	DIABETIC		REDUCTION		HIGH IRON HIGH PROTEIN	HIGH CALORIE HIGH VITAMIN	PREGNANCY	BLAND, ULCER, LOW RESIDUE			
PROCESSED FRUITS AND VEGETABLES	Servings of Vegs. & Frts. per Day ^{1, 2}	Total Canned Vegs. & Frts. per Month	Servings of Vegs. & Frts. per Day ^{1, 2}	Total Canned Vegs. & Frts. per Month				Servings Bland Vegs. & Frts. per Day ^{1, 2}	Total Canned Bland Vegs. & Frts. per Month ¹		
	5	4 lbs.	6	4 lbs.	Same as Reduction Diet	Same as Reduction Diet	No Additional Canned Frts. & Vegs.	4	4 lbs.		
	6	8 lbs.	7	8 lbs.				5	8 lbs.		
	7	12 lbs.						6	12 lbs.		
MEATS	Prot. per Day in Gms.	Meat ³ per Day in Gms.	Meat ⁴ per Mo. in Lbs.	Prot. per Day in Gms.	Cal. per Day	Meat ³ per Day in Gms.	Meat ⁴ per Mo. in Lbs.	90 Gms. & Over Prot. per Day	Meat per Month 6 lbs. ⁴	Prot. per Day 90 Gms.	No Additional Meat Required
	50	50	5	60	600	90	9	Meat per Month 20 lbs. ⁴			
	60	90	9	70	900	130	12				
	70	130	12	80	1200	170	16				
	80	170	16	90	1500	210	20				
	90	210	20		or more						
	or more										
FATS	Fat per Day in Gms.	Rationed Fat ⁵ per Day in Gms.	Rationed Fat per Mo. in Lbs.	Cal. per Day	Rationed Fat ⁵ per Day in Gms.	Rationed Fat per Mo. in Lbs.	Rationed Fat per Month	Fat per Day 180 Gms.	Rationed Fat per Month	No Additional Rationed Fat Required	
	60	20	1½	600	None	None	3 lbs.	Calories per Day 3000 or over	3 lbs.		
	80	45	3	900	10	½					
	100	70	4½	1200	20	1½					
	120	95	6½	1500	35	2½					
	140	120	8	or more							
	160	145	9½								
	180	170	11					Rationed Fat per Month 9 lbs.			
200	195	13									

¹For each additional serving of fruits and vegetables, add 4 lbs. canned fruits and vegetables per month.

²Four servings (½ cup or 100 grams each) of fruits and vegetables per pound.

³Cooked weight, edible portion.

⁴Rationed meat, as purchased, 25% allowed for waste and 25% for shrinkage.

⁵This figure includes bacon, cooked weight.

Table 2.—Calculations for the Point Values of One Pound Units of Rationed Meats, Fats and Processed Vegetables and Fruits

	Amount in Pounds	Rationed	Point Value ¹ per Pound	Point Value for Amount Used
Canned Fruits and Vegetables for Bland Diets	.25	Peas.....	13	3.25
	.15	String Beans.....	11	1.65
	.10	Tomatoes, strained.....	13	1.30
	.25	Peaches.....	13	3.25
	.25	Pears.....	11	2.75
1.0 Pound Unit Canned Bland Fruits and Vegetables = 12.20 (12) points				
Canned Fruits and Vegetables for All Other Diets	.10	Peas.....	13	1.30
	.15	String Beans.....	11	1.65
	.25	Tomatoes.....	13	3.25
	.10	Peaches.....	13	1.30
	.10	Pears.....	11	1.10
	.10	Apricots.....	13	1.30
	.15	Red Cherries.....	11	1.65
	.05	Pineapple.....	15	0.75
1.0 Pound Unit Canned Fruits and Vegetables = 12.30 (12) points				
Meat and Cheese for All Diets	.1	Beef Rib, 7 inch cut.....	8	.8
	.2	Beef Chuck, bone-in.....	6	1.2
	.2	Beef, Round.....	8	1.6
	.1	Beef Liver.....	6	.6
	.1	Lamb, Loin Chops.....	8	.8
	.1	Pork, Center Chops.....	7	.7
	.1	Veal, Round Steak Cutlets.....	8	.8
	.1	American Cheese.....	8	.8
1.0 Pound Unit Meat and Cheese = 7.3 (7) points				
Fats for All Diets	.3	Bacon, Sliced, rind off.....	8	2.4
	.5	Butter.....	8	4.0
	.1	Oil.....	6	.6
	.1	Shortening.....	5	.5
10.0 Pound Unit of Fat = 7.5 (8) points				

¹Point Values for April 1943.

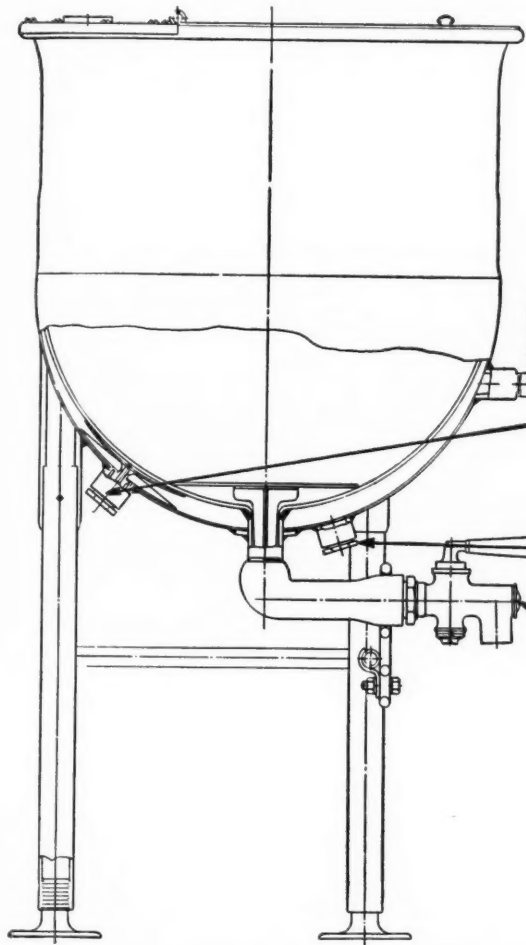
nancy, bland, ulcer and low residue diets, substitute one quart for one pint of milk daily.

Table 2 outlines a plan for calculating point values for pound units for rationed processed fruits and vegetables and meats and fats. By this method units can be recalculated readily whenever new point values for individual foods are announced by the Office of Price Administration. From time to time it will probably be wise to reconsider the foods upon which point values are based.

Additional points for therapeutic diets should be requested for a limited time only. Six months is suggested for diabetic diets and two months for all other diets.

With table 1 as a guide, amounts of rationed foods needed for therapeutic diets may be expressed in pounds, or in points, by multiplying the number of pounds required of each class of foods by the unit point value given in table 2.

INSTRUCTIONS FOR PROPER MAINTENANCE OF WEAR-EVER STEAM-JACKETED KETTLES



Proper care of kettles is vitally important these days. To make your Wear-Ever Steam-Jacketed Kettles last longer and serve you most efficiently, follow these instructions carefully and check to see that your kettles are correctly installed:

General Instructions for all types of Kettles

- ① Clean them thoroughly, inside and outside, every day.
- ② **Safety Valve:** Chain on handle of safety valve should be pulled daily to insure proper functioning. Replace missing valves.
- ③ **Steam Inlet:** Be sure steam intake line is attached to this specific fitting which is provided with a baffle plate. Steam intake pipe should be same size as the inlet fitting for at least the last 30 inches in the line.
- ④ **Steam Outlet:** Steam return line should be equipped with a good grade condensation trap of proper size. Condensed steam must be removed from jacket for efficient performance.
- ⑤ **Draw-off Faucet:** Take advantage of clean-out features that are provided in faucet for long life and convenience.

Additional Instructions for Trunnion Type Kettles

- ① **Drain Valve:** When operation begins from a cold start, open drain valve at bottom to bleed water from jacket.
- ② **Packing Nut Gland:** Tighten this nut occasionally to prevent leakage.
- ③ **Handle Assembly:** Remove handle lock screw occasionally to clean out and oil assembly.

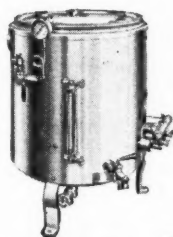
Additional Instructions for Gas-Heated Kettles

- ① Be sure water in jacket is at all times maintained at proper level as shown on gauge glass. If kettle is allowed to boil dry, damage will result.
- ② Clean gas fixtures regularly to maintain proper flow and combustion of gas.

For further information on the use and care of your kettles, write for the book, "Wear-Ever Steam-Jacketed Kettles". The Aluminum Cooking Utensil Company, 707 Wear-Ever Bldg., New Kensington, Pa.



Deep Type
Kettle



Gas-Heated
Kettle
Trunnion Type
Kettle



Shallow
Type
Kettle

Wear-Ever



Aluminum

★ WHEN IT'S ALL OVER W-E WILL BE BACK! ★

"Volunteers Serve Us Well"

FOR the last seven months we have had the assistance of Red Cross canteen workers in the dietary department of the Hospital of the Woman's Medical College of Pennsylvania, Philadelphia.

Inasmuch as these volunteers had completed a standard course in nutrition and were ready to give their services when they came to the hospital, we planned our program around definite assignments for them so that from the very beginning they felt that they contributed to the smoothness of operations and that they were assisting in carrying out our aims in a good program of nutrition.

As one worker expressed it, "We have been taught certain technics in food preparation. It is nice to work in a place where these are actually put in practice."

Following is an outline of the duties of these volunteers:

1. Report to the dietitian on arrival, checking with her on the

EMMA JANE BEYDLER

Administrative Dietitian
Hospital of the Woman's
Medical College of Pennsylvania
Philadelphia

menu, food preparation required, quantities and size of servings.

2. Make salads and store them in the refrigerator for serving time.

3. Serve desserts.

4. Take complete charge of the cafeteria counter, one worker being responsible for the hot foods and one for cold foods and beverages.

5. Keep a careful check on cold and hot foods, notifying a kitchen employe who is responsible for their replenishment.

6. Keep a meal count.

7. Assist with salad, dessert and fruit preparations for next meal.

8. Assist the dietitian with tray service.

The corps is divided into two groups of two volunteers each. Group 1, which assists with the noon meal, serves from 10:30 a.m. to 1:30

p.m. five days a week, and group 2, assisting with the evening meal, serves from 3:30 to 6 p.m. six days a week.

Quite frequently workers who report at 10:30 a.m. ask to remain to help us with the food preparation for the evening meal.

The present schedule totals sixty hours weekly. Realizing that the majority of these assistants are homemakers and are donating their services we do not feel that we can reasonably expect additional time other than that which they themselves suggest giving. However, the time spent during meal hours is ample to complete the services required.

We have enjoyed having these workers in the department and are constantly impressed by their attitude. They are eager and willing to assist and their presence has entailed few problems. There were at first, of course, the difficulties of adjustment to a new environment but these were soon overcome.

For a Menu Without Meat

ECONOMY of money and points is achieved in a timely and appetizing dish suggested by the Irradiated Evaporated Milk Institute. Noodles baked in a creamy custard

make an appetizing and attractive accompaniment for creamed meat, poultry, fish or seafood. The custard is firm but tender and moist. The concentrated milk also provides a

double share of whole milk nutrients plus vitamin D.

Noodle Ring Fifty Servings

- 2 lb. broad noodles
- 2½ gal. boiling water
- 2½ tbs. (1¼ oz.) salt
- 20 eggs
- 2½ pt. evaporated milk
- Pepper to taste
- ½ cup (4 oz.) butter

Drop noodles into boiling water to which salt has been added. Boil until tender, about ten minutes. Drain and rinse. Add beaten eggs, milk and pepper. Pour into well-greased ring molds or shallow baking dishes or individual baking dishes. Dot tops with butter. Bake in a slow oven (300° F.) until set but not brown, about forty-five minutes. Turn onto a hot platter and fill rings with creamed chicken, veal or fish. If baked in shallow pans, cut in squares to serve. Grated cheese (2 pounds for the 50 servings) may be added to the mixture before baking.



Economy is combined with eye appeal in this noodle ring, which will go far toward stretching the allotment of creamed fish, poultry or meat.

MEAT GOES FARTHER

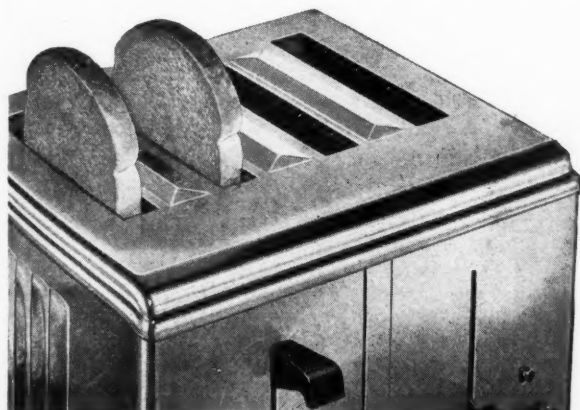


...when TOASTMASTER TOAST is part of the recipe!

• Menu planning is a tough job these war-restricted days—but smart dietitians make it easier by using TOASTMASTER TOAST in the recipe. This one simple ingredient (that costs so little itself!) stretches meat a long way...makes countless dishes more attractive, more satisfying, more temptingly

delicious. It's a familiar touch, too, because millions get TOASTMASTER TOAST at home and *prefer* its "melt-in-your-mouth" goodness. If you're lucky enough to have a TOASTMASTER TOASTER, use it often to add menu-variety, to keep costs down, to keep up your food reputation. Send for our illustrated recipe book "Toast Treats for the Hospital Diet"—it's free!

DON'T NEGLECT YOUR TOASTMASTER TOASTER—if you clean it daily and don't let the help abuse it, it will serve you well until we can again fill civilian needs. If it needs adjustment or repair see your dealer or write us. For new parts, be sure to return the old ones.



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THE NATIONAL HABIT
AT HOME AND IN PUBLIC **TOAST**

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August Dinner Menus for the Small Hospital

Myrtis B. Stolz

Dietitian, Sanitarium of Paris, Paris, Tex.

Day	Soup or Appetizer	Meat, Fish or Substitute	Potatoes or Substitute	Vegetable	Salad or Relish	Dessert
1.	Consommé	Baked Ham, Gravy	Steamed Rice	Swiss Chard	Sliced Tomato Salad	Bavarian Cream
2.	Vegetable Soup	Grilled Lamb Chops, Mint Sauce	Creamed Potatoes		Asparagus Salad	Thompson Grapes
3.	Cream of Corn Soup	Noodle and Egg Casserole	Tiny Beets	Garden Peas	Fresh Fruit Salad	Frosted Cup Cake
4.	Scotch Broth	Fried Chicken	Cream Gravy	Baby Lima Beans	Head Lettuce, Thousand Island Dressing	Sponge Cake, Vanilla Cream
5.	Split Pea Soup	Roast Beef	Corn on Cob	Baked Summer Squash	Grapefruit and Orange Salad	Peach Shortcake
6.	Consommé à la Royale	Broiled Fish, Lemon	Boiled Potatoes	Green Beans	Crisped Celery	Green Gage Ice
7.	Cream of Potato Soup	Savory Baked Ham	Jolly Boys*	Spinach With Lemon	Lettuce and Tomato	Raspberry Ice
8.	Chilled Tomato Juice	Roast Leg of Lamb	Drop Dumplings in Chicken Broth	French Peas	Raw Vegetable Salad	Prune Whip
9.	Consommé	Pan-Boiled Tenderloin Steak	Steamed Rice	Small Glazed Onions and Carrots	Celery Hearts and Olives	Cottage Pudding
10.	Strained Vegetable Soup	Fried Fish	Creamed Potatoes	Buttered Okra	Fruit Gelatin Salad	Pineapple Ice
11.	Tomato Soup	Chicken With Dumplings		Buttered Asparagus	Coleslaw	Peppermint Ice
12.	Vegetable Soup	Roast Beef	Creamed Potatoes	Blushing Cauliflower	Stuffed Prune Salad	Whole Egg Muffins, Orange Sauce
13.	Tomato Juice	Broiled Red Snapper, Lemon Sauce	Buttered Potatoes	Spiced Beets	Cucumber Boats	Orange Sherbet
14.	Vegetable Soup	Roast Chicken	Potatoes in Cream	String Beans	Head Lettuce	Fresh Peach Sherbet
15.	Clear Vegetable Soup	Roast Beef, Brown Gravy	Fluffy Rice	Buttered Onions	Endive Salad	Fresh Pears
16.	Chicken Bouillon	Roast Leg of Lamb	Creamed Potatoes	Glazed Carrots	Fruit Salad	Lemon Chiffon Pie

* American Cookery, February 1937

(Continued on page 104)

On their War Record...



Sunfilled pure concentrated
ORANGE and GRAPEFRUIT JUICES
 will simplify the economical
 planning of post-war menus



CITRUS CONCENTRATES, INC.
 DUNEDIN, FLORIDA

As previously announced, the total output of Sunfilled concentrated citrus fruit juices has been drafted for service of the armed forces. Not only have they provided a solution to the problems of perishability and cargo space required to transport bulky fresh fruits . . . they afford the equivalent in flavor, body, nutritive values and vitamin C content as well. This achievement of Sunfilled Products means a better balanced diet for our fighting forces and those of our allies receiving them as lease-lend supplies.

Sunfilled quality, economy and convenience count today! These dependable qualities will also serve to advantage in the planning of post-war menus. Until present restrictions are modified, available fresh fruits, though more costly and less convenient to prepare, should prove adequate for civilian needs.

No Shortage!



Kellogg's Cereals provide whole grain nutritive values in Thiamin (Vitamin B₁), Niacin and Iron . . . supply an average of 6.7 grams of protein in a normal serving of cereal and milk.

KELLOGG'S CEREALS ARE PLENTIFUL!

Give patients all they want. You'll save on "shortage" foods . . . save time, work, fuel and you'll be sure of serving cereals that provide whole grain nutritive values.

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August Dinner Menus for the Small Hospital

Day	Soup or Appetizer	Meat, Fish or Substitute	Potatoes or Substitute	Vegetable	Salad or Relish	Dessert
17.	Cream of Spinach Soup	Macaroni and Cheese		Stewed Tomatoes	Cherry and Pineapple Gelatin Salad	Bavarian Cream
18.	Clear Soup	Smothered Chicken	Wax Beans		Raw Vegetable Salad	Grape Ice, White Cake
19.	Strained Vegetable Soup	Steamed Liver	Creamed Onions	Stewed Tomatoes	Wilted Lettuce, Minced Bacon	Apple Dumplings
20.	Tomato Bouillon	Broiled Red Snapper	Parsley Potatoes	Green Beans	Coleslaw	Lemon Ice, Cookies
21.	Clear Vegetable Soup	Fried Chicken	Cream Gravy	English Peas	Combination Salad	Baked Peaches
22.	Cream of Celery Soup	Veal Pot Roast		Buttered Spinach	Grapefruit and Orange Salad	Peppermint Ice
23.	Noodle Soup	Baked Ham	Thin Corn Muffins	Mustard Greens	Vinaigrette Beets	Baked Apples
24.	Celery Hearts	Creamed Chicken in Rice Nests		Buttered Asparagus	Tomato Aspic Salad	Sugarless Layer Cake
25.	Fruit Juice	Roast Chicken	Light Bread Dressing	Creamed Carrot and Young Turnip Balls	Endive Salad	Pineapple Sherbet
26.	Cream of Corn Soup	Steamed Steak	Fluffy Rice	Creole Okra	Orange and Grapefruit Salad	Caramel Pudding
27.	Clear Soup	Baked Red Snapper	Shoe String Potatoes	Buttered Green Lima Beans	Stuffed Celery	Sliced Peaches
28.	Clear Vegetable Soup	Smothered Chicken	Creamed Onions	Baked Squash	Lettuce, Thousand Island Dressing	Peppermint Ice
29.	Vegetable Soup	Pot Roast	Creamed Potatoes		Cucumber-Tomato Salad	Fruit Cobbler
30.	Cream of Celery Soup	Breaded Veal Chops	Stuffed Potatoes	French Peas	Head Lettuce, French Dressing	Peach Shortcake
31.	Bouillon	Spaghetti Casserole		Buttered Parsnips	Mellon Ball Salad	Lemon Ice

Recipes will be supplied on request by The MODERN HOSPITAL, Chicago



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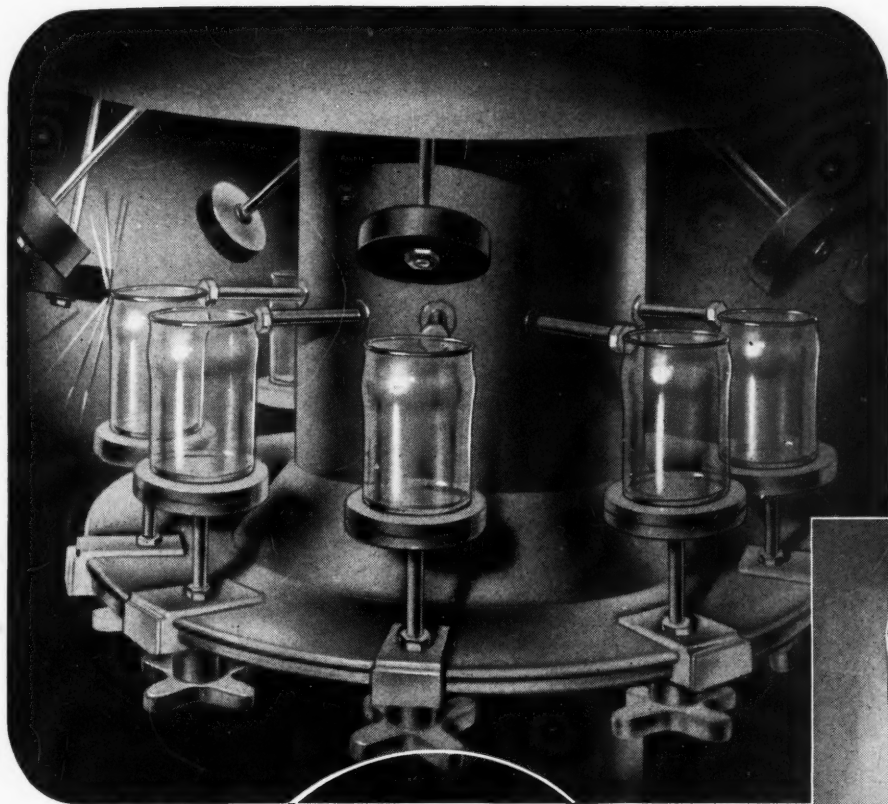
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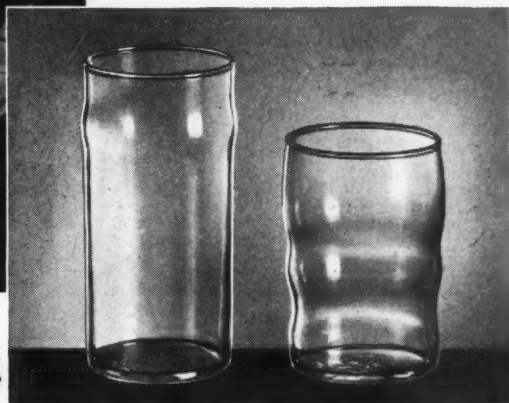
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and the brilliance and attractiveness of the glass are in no way impaired by the heat treatment.

Libbey "Heat-Treated" Safedge Tumblers are priced slightly higher than regular Libbey Safedge glassware because of the additional manufacturing operation. However, the longer service they will give your hospital makes them a real economy.

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Gentlemen: Please send me full information about the new Libbey "Heat-Treated" Safedge Tumblers for hospital use.

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DEMAND Exceeds SUPPLY of Drugs and Fine Chemicals

THERE can be no intelligent discussion of the fine chemical supply situation without a full realization of supply and demand in the underlying national position of basic chemicals, and by these are meant phenol, nitric acid, chlorine, benzol and the like.

Under the protection of favorable tariffs brought about by forward-thinking chemists and a sympathetic governmental attitude after the last war, the American chemical industry, which had already adopted a far-sighted policy of pure and applied research, exploited the opportunities that were abundantly available and at the beginning of World War II had reached a high degree of expansion.

Surplus for Exports Built Up

Not only had our chemical expansion reached the point where it could provide for the needs of 130,000,000 population rapidly becoming chemically minded, but, as government statistics will show, it had built up exportable surpluses of formidable proportions.

It would never have occurred to an impartial commentator, had he investigated the chemical industry in June 1939, that there was likely to be a shortage of any basic chemical in three short years. Of course, we know that it is not now, or never was, a question of curtailed production that brought about the current chemical shortage as such, but rather a grave miscalculation of the staggering requirements of a modern war, on top of today's application of chemistry to the most commonplace of civilian requirements.

An attempt to determine which basic chemical is most important to

Abstracted from a paper presented at the Midwest Hospital Association meeting, 1942.

H. T. POWELL

The McPike Drug Company
Kansas City, Mo.

the war effort, on the one hand, and to essential civilian requirements, on the other, is simply begging the question, inasmuch as the war needs of chemicals are interrelated to the point where segregation into groups by relative importance is not, practically, possible. But let us take a few groups known to be important, examine their position as best we can today and explore their effect on fine and medicinal chemicals.

Phenol, now being allocated by the War Production Board, has been on the critical materials list since the beginning of our defense program. Its war use is basic and prodigious efforts have been made to expand its production, and with notable success. Yet the ever-increasing war demand permits no improvement in the civilian supply.

Actually, phenol is the starting point for the coal tar medicinal and fine chemical industry. One has only to mention such well-known products as aspirin, salol, sodium salicylate, saccharin, resorcin, the sulfocarbolates and numerous synthetic products in order to realize how far-reaching is its effect on fine chemicals and how essential it is to the war effort.

Toluol, which is necessary in the production of TNT, is another case in point. It is closely allocated by the W.P.B., restricted to certain uses only and given priority ratings as to those uses. Production capacity has been greatly expanded, yet so great are the war demands that, notwithstanding newly developed manufacturing facilities, civilian use, includ-

ing drug extraction, is subject to strict control. Toluol has many laboratory and manufacturing uses, particularly as a solvent in the extraction of the active principles from plants. It is employed in the manufacture of benzoic acid and benzaldehyde.

Benzol, another important solvent, has wide use in the manufacture of medicinal chemicals, among other things. It, too, has its war rôle and its total consumption is close on the heels of production.


Another entirely different group of basic chemicals may, by reason of their interrelationship, be treated together, theoretically at least. They are: *methanol, ammonia and nitric acid*. Each of these has an irreplaceable part in the war production program.

Methanol, best known for its anti-freeze properties, is employed in vast quantities for this purpose by the motorized units of the armed forces. It is, furthermore, a necessity in explosive production and the essential factor in the manufacture of formaldehyde and methyl salicylate.

Formaldehyde, in addition to its use as a germicide and disinfectant, is largely employed in the production of plastics which are substituted for certain metals in war uses. While the development of plastics will probably not be limited by the availability of formaldehyde, it is nevertheless safe to say that formaldehyde is today more important in the field of plastics than in any other.

Nitric acid, No. 1 nitrating material for explosives, has probably more numerous and varied uses than any of the basic chemicals under discussion. In fine chemical production, it is necessary in the manufacture of bismuth salts, silver nitrate, ammonium nitrate and others.

Chlorine, under normal conditions,

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to their self-appointed tasks
have come the great gifts
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has a broad and important field of use in civilian requirements. Approximately 25 per cent of total production was consumed by the paper industry for bleaching stock. Other important quantities are employed in the manufacture of fine and medicinal chemicals, such as chloroform, calomel, chlorobutanol and chloral hydrate. Still further capacity has been devoted to production for water and sewage purification, a use that is now multiplied by Army needs.

Zinc war needs in 1917 pumped national production up to 670,000 tons of slab, a level not again reached until 1940, when this figure was passed. On the critical materials list since the outset of the war program, zinc continues to be in short supply, although slight easing is apparent from time to time. In the United States, zinc consumption is accounted for by a relatively small number of industries; galvanizing and brass normally consume approximately three fourths of the zinc produced.

Zinc Needed in Industry

Today, with the need for galvanized metals vastly expanded for maritime uses and the untold requirement of brass for small and medium caliber shells, the amount of zinc available for the oxide and zinc salts must be carefully gauged. Zinc oxide has many uses in industry, exceeding the country's requirements for pharmaceutical and cosmetic uses. Thus, the drug trade shortage of zinc oxide is directly due to the demands made upon zinc slab production for war uses.

Mercury, recently placed under conservation, has wide industrial and drug use. It has no peer in its use in instruments of control, a use that has greatly increased in both military and manufacturing technics. Its salts, such as the chlorides, oxides and ointments, have wide use in medicine as well as in certain types of industrial products, *i.e.* anti-fouling paint, germicides, fungicides and pigments, to speak of only a few of them.

Consumption of mercury metal has been stabilized at the level of previous base period quantities for the production of derivatives for certain purposes (medicinal 100 per cent). It was banned after April 1, 1942, for some uses (turf fungicides,

for example) and materially reduced for other nonspecified purposes.

Other fine chemicals not necessarily dependent upon the basic chemicals discussed are nevertheless in short supply for the reason that the production facilities of manufacturers normally producing them are required for the production of other and more critical materials. This is a condition that will no doubt become more aggravated as general manufacturing conditions are required to conform to the needs of the war program.

Fine Alkaloids are in restricted supply. For years intermittent efforts to propagate the crude materials needed for the extraction of the active principles have been made in the United States. At present an important program in this direction is afoot. Meanwhile, the supply of some of these important drugs is doubtless sufficient to take care of "must" requirements, while others are the subject of intensive research to determine their chemical structures as the first step in synthesizing them.

A notable achievement has been made in this field since the outbreak of the war. Ephedrine, important in such respiratory ailments as asthma and formerly extracted from the Chinese drug herb Ma Huang, is now produced synthetically and at levels calculated to keep pace with the growing demands made upon it. Through forward-looking action on the part of the government and the manufacturers, supplies of raw materials for the manufacture of quinine and narcotic drugs are already in stock in the United States.

We Share With Allies

No reference to the fine chemical and drug supply situation can be complete without reference to the humanitarian policy of the federal government, which, through its Lend-Lease and Pan American programs, is making available to the United Powers and the Western Hemisphere nations such quotas of our own national supplies as it is possible to make.

This is not a policy of exporting what can be spared from our own needs but one of sharing our available supplies with our friends throughout the world. Thus, business-as-usual is again relegated to the limbo of prewar practices and supply situations, normally adequate,

must now be properly considered in the light of war conditions.

It is imperative to remember that, if every prospective user of medicinal chemicals and drugs undertook to cover his requirements beyond a thirty day period, the supplies of these products extant in the United States would fall far short of adequacy. On the other hand, even the most strictly limited materials can, if allocated judiciously, serve the country's needs for a considerable time to come.

Nowadays, when a prospective purchaser has been fortunate enough to locate a supply of material that he needs, he finds in some cases that he is next confronted with the equally difficult problem of obtaining it. This condition, where it exists, is not the fault of the priorities and allocations system so much as it is the lack of understanding of the immensity and essentiality of the war problem by the would-be purchaser. This is an unpleasant fact, but one that must be understood and accepted.

War Needs Come First

It will be enough to remark that the authority of the War Production Board to develop and put into effect the system of priorities and allocations is well established at law. Basically, the purpose of preference rating orders is to control the distribution of available materials so that the war needs will first be satisfied and the essential civilian requirements taken care of.

Priority orders are issued for the purpose of enabling those whose needs are requisite to obtain the materials essential to their needs. It is not intended that priorities will be employed when the needed materials can be obtained without them. Allocations are, for all practical purposes, priorities that are directed by the appropriate official of the War Production Board to a manufacturer with the intent that he will supply a specified quantity of a specific material to a definite consumer.

Priorities and allocations are made effective by the issuance by the War Production Board of General Preference Orders of four categories*: (1) the "P" series, which briefly assigns preference ratings to uses; (2) the "M" orders, which direct the distri-

*While the War Production Board is now renumbering all forms, the old numbers, as used in this article, will continue to appear for some time.

MARGIN OF SAFETY

IN A STUDY of various barbiturates, Allonal's hypnotic component, allyl-isopropyl-barbituric acid, was found to have a wide margin of therapeutic safety—twice that of barbital and nearly three times that of phenobarbital. Because of this relatively wide margin of safety—because it produces restful sleep, even in the presence of pain, Allonal deserves to be your routine sedative-hypnotic of choice. HOFFMANN · LA ROCHE, INC. • NUTLEY, N. J.

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bution of specific commodities (these also direct the conservation of materials where required); (3) the "E" orders, which control the distribution of machine tools and cutting tools, and (4) the "L" orders, which set limits on the production of materials or supplies.

This article will concern itself only with some of the "P" and "M" series orders. There are approximately 90 orders, covering a wide variety of industries and uses, made available on application. P-43 enables research laboratories to obtain the necessary supplies and equipment to permit them to carry on their important fact-finding research work. This order carries an AA-2X rating to holders of a serial number and AA-4 to those without the serial number. Such serial numbers are made available to research laboratories upon application to and approval by the War Production Board. This order is now being revised.

In the drug field, Order M-7 covered borax and boric acid and, although it has since been revoked, it put the materials under full priority control to meet a temporary shortage threatened by a strike. M-41, issued in October 1941, covered chlorinated hydrocarbon solvents, sharply restricting the use of carbon tetrachloride (for one) in a series of uses and assigning preference ratings to the various uses covered by the order.

This order required the consumer purchaser to file a report, covering his inventory and use, with quantities involved over a designated period.

M-34, covering toluene, was amended in late December 1941 to require that after the first of February 1942 and in subsequent months, no order for certain grades of toluol could be delivered by a supplier unless he filed a prescribed form with his supplier prior to the tenth of the month preceding that in which the customer desired delivery. The supplier, in turn, submitted to the War Production Board a schedule of his anticipated shipments, properly authenticated, and made such shipments against schedules that were subsequently directed by the War Production Board.

The effect of the "M" orders has been to restrict the use of the materials covered for specified purposes, either through conservation of the raw material, as in the case of mer-

cury; restriction or discontinuance of the use of the finished material for specified purposes, or through limitation of the sale by requiring reports on controlled use and inventory. That the conservation of the national supplies of many materials is an accomplished fact is indicated by revocation of the order in at least one instance.

The number of controlling "M"

orders is increasing daily and is slowly covering a wide selection of metals and salts and other materials as well. In most cases, relief from the application of the order is provided for and manufacturers in the drug and fine chemical field have been successful in effecting exemptions in some cases, covering the distribution of items in small unit sizes and quantities.

NOTES AND ABSTRACTS

Conducted by the Staff of the Pharmacology Department
Wayne University, Detroit

Penicillin

Penicillin is one of a group of new bactericidal agents derived from bacteria or fungi. Another member of this group, gramicidin, was discussed in this column in the October 1942 issue of *The Modern Hospital*.

Penicillin is relatively nontoxic, is bacteriostatic and may be bactericidal under certain conditions. Unlike any of the chemotherapeutic substances now in use, it is not hemolytic or insoluble, nor is it a detergent. Moreover, its action is not inhibited by para-amino-benzoic acid or by the products of tissue destruction.

Origin. The mold *Penicillium notatum* was observed by Fleming in England in 1929, growing as a contaminant of nutrient agar media. In the presence of the mold the growth of pyogenic cocci was inhibited. Culture filtrates, he found, contained a soluble principle, penicillin. He applied the new agent as a bacteriological tool for the isolation of the influenza bacillus.

In 1935 Florey, Abraham, Chain and others at the Oxford School of Pathology initiated their studies concerning methods of preparation, toxicology, pharmacology and therapeutic application of this new agent. Results of their work were first reported in 1940 and were summarized in preliminary form in 1941.

Production, Assay and Purification. The most formidable impediment to the rapid study and therapeutic application of penicillin has been the difficulty of production of sufficient quantities of the material. The mold is grown in a thin layer of modified Czapek-Dox medium under aerobic conditions at room temperature. The aqueous broth removed from beneath the growth of mold contains the active substance in dilute form.

Assay of the bacteriostatic activity of penicillin is accomplished by two methods giving comparable results. The original Oxford unit was determined by

measuring the diameter of the zone of inhibition about a vertical tube containing the substance to be tested. This tube was placed in the center of an agar plate which was seeded with a known test strain of organisms.

Meyer, Hobby, Chaffee and their co-workers in New York utilized the simpler method of observing clouding in serial dilutions of the bacteriostatic material in tubes containing a known quantity of bacteria.

Aqueous broth from cultures of *Penicillium notatum* contains from 1 to 2 units of active ingredient per cubic centimeter, but by processes of extraction this material can be concentrated and rendered pyrogen free, suitable for therapeutic administration. Purification methods consist essentially of extraction of the active constituent in ether or of saturation with ammonium sulfate and extraction with chloroform at an acid pH and subsequent removal by phosphate buffer at about pH 7.

Penicillin thus prepared has a deep reddish orange color that becomes yellow on dilution, has a potency of from 40 to 240 Oxford units per cubic centimeter, according to the culture or method of extraction used, and may be obtained as free acid or converted to sodium, calcium, ammonium or other salts that are more stable.

Bacteriostatic Activity. When tested *in vitro* against cultures of test organisms penicillin was found to be highly effective against *N. gonorrhea*, *M. meningitidis*, *Staph. aureus*, *Str. pyogenes*, *B. anthracis*, *A. bovis*, *Cl. tetani*, *Cl. Welchii*, *Cl. edematiens*, *Str. viridans*, pneumococcus and *C. diphtheriae* and fairly effective against many others. However, marked differences have been observed in susceptibility of different strains of the same organisms.

Its bacteriostatic action is as great or greater than that of the most powerful antiseptics. Activity of the substance

IN THE TREATMENT AND HEALING OF WOUNDS



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SULFANILAMIDE

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Indications for local application are similar to those for sulfanilamide. Preferable for known pneumococcal or staphylococcal infections. For mixed infections, a combination of sulfanilamide and sulfathiazole is advocated.

ZINC PEROXIDE SPECIAL MEDICINAL

For wounds contaminated with anaerobic or micro-aerophilic streptococci, the gas gangrene clostridia, or the non-spore-forming anaerobic bacilli. This form of treatment may be usefully supplemented by the systemic administration of a sulfonamide.

MECHOLYL CHLORIDE

Increased local circulation follows administration by ion transfer. Of value in stimulating the healing of chronic ulcers.

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A satisfactory nutritional state with respect to vitamin C is important to normal wound healing. Required for the formation of intercellular substances.

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Controls the tendency to hemorrhage in patients having a lowered prothrombin content of the blood in the absence of liver damage, by restoring the prothrombin content to normal.

o o o

LITERATURE ON REQUEST

seems not to be adversely affected by numbers of bacteria in the inoculum material, nor is its bacteriostatic power antagonized by proteins or pus, suggesting its use in the local treatment of purulent and heavily infected wounds. Moreover, it is not inactivated by the presence of para-amino-benzoic acid as are the sulfonamides.

The exact mode of bacteriostatic action of penicillin is not known, but it appears to be similar in mechanism to the sulfonamides. It is known that it interrupts the pathogenic career of the infecting organism by blocking some step in its metabolic path. It has been found

to prevent cellular division of bacteria, resulting in giant forms. This interference with bacterial multiplication is borne out by the observation that penicillin has no inhibiting action *in vitro* unless the culture material is in an actively growing state.

Toxicity. Penicillin is relatively non-toxic within the range of therapeutic dosage. This fact has been demonstrated in animal experiments and in human therapy. In the latter field not a single adverse reaction attributable to the purified drug has yet been reported. *In vitro* there was no toxic effect on leukocytes in a concentration of 1/500, signifying

that penicillin is less toxic to cells than are the sulfonamides. Tissue culture studies and *in vivo* injections into nervous tissue show that the material is relatively innocuous.

Absorption and Excretion. Animal and human studies show that it is absorbed from the intestine if placed beyond the reach of the inactivating acidic reaction of the stomach and remains in the bloodstream for about three hours. After intravenous administration penicillin can be demonstrated in blood for about one and a half hours. Fifty per cent of the drug given can be extracted from the urine in an active form. The rapid excretion of penicillin is a factor that demands either slow continuous infusion or frequently repeated administration of fairly large quantities in order to maintain bacteriostatic concentrations.

Methods of Administration. The oral route of administration is difficult and not very effective. Florey found the intramuscular route, which caused no local tissue reaction with multiple injections, to be most practical when repeated doses of 15,000 Oxford units were given every three hours. Herrell, at the Mayo Clinic, found continuous intravenous injections most suitable. For moderately severe cases he advised from 30,000 to 40,000 Oxford units in twenty-four hours.

One half of the dose in one liter of saline, glucose or distilled water was started fairly rapidly for the first 100 to 200 cc., then given at a rate of 30 to 40 drops per minute. The second liter was started from 8 to 10 hours later. When penicillin was applied to local lesions a much smaller quantity was required.

Therapeutic Applications. Early reports of the therapeutic use of penicillin are beginning to appear. Florey described a series of 15 serious illnesses in which treatment was given by mouth, intramuscularly and/or intravenously. Ten cases of staphylococcal infection, one of streptococcal meningitis, three of actinomycosis or streptothrix and one of subacute bacterial endocarditis were included. All the staphylococcal cases recovered with healing of the local lesions as the result of parenteral administration of penicillin. He noted that healing of the bony lesions in osteal infections was most striking.

Herrell reported 10 cases of systemic infection treated with penicillin by continuous intravenous infusion. In eight cases of *Staphylococcus aureus* and one of *Streptococcus hemolyticus* infection satisfactory results were obtained. In one case of *Streptococcus viridans* endocarditis, as in Florey's case, the result was unsatisfactory. Clearing the blood stream of organisms in the patient with endocarditis occurred during penicillin administration, but the bacteria reappeared immediately thereafter.

HOSPITAL LIQUIDS First AGAIN!

In "Hospitals" April, 1943, Charles O. Auslander*, in his article "Purchasing Hospital Supplies in War Time and Post-War Planning," says that viscose tubing to replace rubber tubing for transfusions is an example of substitution that may prove of great value.

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*Auslander, Charles O., Hospitals XVII 4, April, 1943, p. 70.



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Florey also reported 172 infections of the eye, mastoid, chronic wound sinuses and miscellaneous septic processes that healed after local treatment with penicillin.

Herrell points out that with the scarcity of the materials available great care in selecting cases for treatment with penicillin should be exercised. He would limit its use to severe cases of Staph. aureus, N. gonorrhea, N. intracellularis, and possibly gas gangrene infections.

Summary. Effort is being made to form more stable salts and esters of penicillin that will be no more toxic than those now in use. With improved meth-

ods of production and purification the therapeutic efficacy of the extract will be expanded and more specifically determined. Penicillin bids fair to replace the

sulfonamides or at least to supplement them, largely because of its high bacteriostatic efficiency and its wide margin of safety.—HAROLD F. CHASE, M.D.

CLINICAL BRIEFS

Conducted by E. M. Bluestone, M.D.

Photomicrography in Color

Photomicrography is an important technic for the dentist and dental research worker. The ease and simplicity

with which kodachrome film can be utilized and the added impressiveness of the material for educational and clinical use, as well as for record purposes, combine to make color invaluable in dental photomicrography.

A. Porter S. Sweet, H. L. Gibson and Charles G. Brownell describe factors that give effective results in "Photomicrography in Full Color," published in the *Journal of the American Dental Association* for April.

Two types of film are used in full color photomicrography. Kodachrome film, type A, which is available in 35 mm. and bantam rolls, is balanced for light sources operating at 3450° K. Kodachrome professional film, type B, in all standard sheet film sizes, is balanced for light sources operating at 3200° K.

The lamp unit must have a housed light source and, if possible, a condenser, a cell for distilled water and a diaphragm.

Light that exposes kodachrome film must have a color temperature of 3450° K for type A or 3200° K for type B. If not, the light source must be changed or regulated by the use of filters, the control of voltage to the lamp or both procedures.

A light source for full color photomicrography must be of the correct color temperature, otherwise results are not satisfactory.

An absolute essential for full color photomicrography is an accurate and reliable shutter providing exposures of from 1 down to 1/200th second.

Any microscope employed for professional work is suitable for full color photomicrography, although a mechanical stage is desirable equipment. Best results are obtained with apochromatic objectives and either compensating oculars or oculars designed for photomicrography.

Any camera that uses film of a size in which kodachrome is supplied is suitable, although one having a long-extension bellows and a ground glass for focusing is preferred.

It is imperative that the apparatus be properly arranged and adjusted. Alignment is important to ensure critical illumination on the specimen. The authors advocate the Kohler method for alignment of the optical system. Obvi-



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*Hirsch, M. M., and Novak, M. V.:
Evaluation of Germicides with Relation to Tissue Toxicity, Proc. Soc. Exper. Biol. and Med., June, 1942.



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ously, the camera must be held securely in position so that it is vibrationless and the planes of the film and microscope stage are parallel.

Since kodachrome film is processed by a reversal method, a black and white reversal material with similar exposure characteristics can be used as a guide to correct exposure. Either a Weston or a General Electric exposure meter is capable of recording at the eyepiece of the microscope light intensities that require an exposure of about one second or less. If a setup requires a longer exposure, an amplification system is necessary. Comparison of the test kodachrome with

the specimen will indicate correct exposure. Any need for adjustment of the illumination can also be determined from this inspection.—DAVID TANCHETER, D.D.S.

Eyes React to Lighting

Efficiency and protection are two aspects of war-time lighting, according to C. E. Ferree and G. Rand in their article "Eye as a Factor in Wartime Lighting," appearing in *Archives of Ophthalmology*, March 1943. Efficient lighting is especially necessary in war production.

Because excessively high intensities of

light are fatiguing to the eye unless diffused, with the glare and brightness from the fixtures eliminated, the authors suggest that a glare baffle or louver be used. Even after these precautions are taken, it is stated that excessive intensities will, over a period of time, prove uncomfortable and fatiguing to the eye.

The authors have examined a large number of persons in order to determine comfortable intensities of light. The wide range of scatter for different ages and for different persons within an age group impressed both.

In general, well-diffused lighting should be used. However, there are some instances in local lighting in which a higher visibility is obtained by lighting that is not diffused, for example, in reading a vernier scale on metal or for detecting scratches or flaws on a metal surface.

Both fluorescent and incandescent lighting will, no doubt, be used in industry during the war. Tests have shown that it is not safe to tinker with color and composition of light without checking its effects on the eye. The eye has developed under daylight and tests have shown that daylight is the best for it.

Because of the acute need for protective lighting in hospitals the authors, at the request of the director of a leading hospital, designed a fixture which is louvered direct-indirect and is equipped with two small lamps for use at night. Night lamps should be on a separate circuit from the primary lamp and of the lowest possible wattage.

For blackout purposes, bulbs may be of dark blue glass or of glass colored by a dark blue heat-resistant dip. Two bulbs are used instead of one in order that no shadow is cast on the ceiling by the primary light. When the light is of the lowest possible intensity, little if any special curtaining is needed to produce an effective blackout.—JOHN F. CRANE.

Mortality in Burns

The inferences to be drawn from recent experiments and reports on the effect of environmental temperature and mortality in burns are set forth in an editorial, "Environmental Temperature and Mortality in Burns," in the *Journal of the American Medical Association* for April 24.

Reviewing the arguments for and against the use of heat *versus* cold as local therapy for injured or infected tissue, the editorial points out that in recent experiments Elman, Cox, Lischer and Mueller have observed striking effects at environmental temperatures of 32°, 55°, 75° and 99° F. Rats under deep anesthesia were subjected to uniform severe thermal injuries involving

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75 per cent of the skin surface. When they were stored at a temperature of 75° F. mortality was from 25 to 32 per cent; however, when the environmental temperatures were raised to 99° F. or lowered to 32° or 55° F. the mortality rose to 100 per cent.

Such evidence, in addition to that of other studies, indicated that the common practice of covering the burned patient with a heat cradle may be definitely deleterious. It also suggests that air conditioning, especially in climates in which summer temperatures rise to 100° F. or higher, may prove an im-

portant method of reducing the mortality caused by severe burns.

Reduction in Wound Fatalities

According to the statistical bulletin of the Metropolitan Life Insurance Company for February, the gross statistics of wound fatalities in the present war are of little value because of (a) the great use of planes, tanks and other mechanized equipment, (b) the creation of deadlier weapons and projectiles, (c) the use of incendiary bombs and (d) the organization of field medical services resulting in the inclusion among

the wounded of many who, in previous wars, would have been recorded as killed.

Despite all this there are available from scattered sources definite indications of improvement in wound fatality rates, owing mostly to such outstanding discoveries as the sulfa drugs, the use of blood plasma and the new types of anesthetics.

In World War I, the gross fatality rate in the American Army was 7.7 per cent. During the first three months of the fighting in the Solomon Islands the rate among Navy and Marine casualties was less than 1 per cent. The mortality from abdominal wounds in previous wars was usually higher than 50 per cent; in the Solomons it has been less than 5 per cent.

Wound infections and gas gangrene are now relatively infrequent because of the sulfa drugs; tetanus has been practically eliminated by routine protection with tetanus toxoid; recovery is frequent even after extensive burns because of the use of blood plasma in the field.—SIGMUND L. FRIEDMAN, M.D.

Using Discards

Because of our great productive capacity and extravagance, many items that should be salvaged and used are discarded. The salvage of all materials other than food stuff is indeed a challenge to an occupational therapy department, according to Virginia Sculim, chief occupational therapist, Pilgrim State Hospital, Brentwood, N. Y., in her article "Use of Waste Material," in *Occupational Therapy and Rehabilitation* for February.

Many materials, formerly regarded as junk and thrown away, are now valuable. Critical items include the following: burlap, bags, packing cases, cardboard cartons, drums, barrels, flour sacks, old nails, sandpaper, linoleum scraps, old newspapers and magazines, bottles and jars. Such properties may be found in any hospital.

A well-trained and experienced occupational therapist will find many uses for such materials and her patients will benefit accordingly. Frequently wonders are accomplished with the barest of necessities.

Working with discarded materials is different from working with new materials. When using discards, the apprehension of spoiling materials does not exist as it does when the material used is new and perhaps costly. Both the patient and the occupational therapist derive satisfaction from their work with salvaged materials, the patient because he has achieved something useful from practically nothing and the therapist because she has demonstrated her ingenuity and originality.—JOHN F. CRANE.



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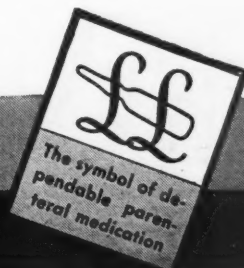
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NEWS IN REVIEW

Bolton Bill, Award of Nutting Plaque Highlights of N.L.N.E. Meeting

Announcement that President Roosevelt has signed the Bolton Bill for the Student War Nursing Reserve on June 16 made one of the highlights of the annual convention of the National League of Nursing Education in Chicago on June 15 to 17. Most of the nursing educators who had worked so hard for the passage of the bill were among the more than 1300 persons who registered at the convention.

Another dramatic event was the presentation to the league of a plaque honoring Mary Adelaide Nutting, first nurse in the world to hold a university chair. The presentation was made by Effie J. Taylor, dean of the Yale School of Nursing and president of the International Council of Nurses, and by Isabel M. Stewart, director of the division of nursing education of Teachers College. Stella Goostray, president of the league, accepted the gift.

Medals, which will be replicas of the plaque, will be awarded periodically to nurses who show outstanding qualities of leadership and to others who render especially meritorious service to nursing.

The league was challenged by James A. Hamilton, president of the American Hospital Association, to ask itself whether it was as desirous of change as it was when organized fifty years ago, whether it demanded revolutionary changes or was satisfied with more gradual development, whether it was striving for a balance between objectives and means, and whether it was acting as a protector of the individual freedom of nursing schools so that federal subsidies, legal and other standards and the accrediting program would not result in putting nursing education in a strait jacket.

The war's effect upon both general and nursing education was hailed as bringing many long overdue changes by several speakers. Prof. Aaron J. Brumbaugh, professor of education, University of Chicago, declared that those colleges that survive the war will never again be what they were but that they will be better.

The four major questions facing nursing education were stated by Miss Goostray to be: (1) acceleration, which should be regarded as an opportunity for educational experimentation; (2) relationship to colleges and universities, from which nursing schools should now seek more help; (3) greater use of auxiliaries and support for approved schools for their training, and (4) public

support for nursing and the maintenance of public interest after the war.

As soon as contact can be established, the International Council of Nurses will begin to study the needs for nursing in its member countries and offer help, according to Effie J. Taylor, president. The council is prepared to offer its services and resources to any national post-war service committee.

The league should admit lay people to membership, in the opinion of Isabel M. Stewart, a recommendation that was unanimously adopted by the league. Hospital and V.N.A. trustees, university faculty members, members of nursing school committees and others with an interest in nursing education may be admitted as full members and will have a representative on the board of directors.

Stella Goostray of Children's Hospital, Boston, was reelected as president; Phoebe M. Kandel of the University of Utah, Salt Lake City, was reelected as vice president; Anna D. Wolf of Johns Hopkins Hospital was elected secretary, and Lucile Petry of the U. S. Public Health Service was reelected as treasurer.

Medical Society Will Collect Data on U.S.S.R. Medicine

To meet the increasing demand in this country for information about achievements in Soviet medicine the American-Soviet Medical Society has been founded to exchange information with the Soviet Union.

Through meetings, the publication of a journal and the establishment of a library of information the society will tell American physicians and members of the allied professions about problems that are being met and solved by Soviet medical men. It will also forward American medical books and periodicals to Russia in order to keep the Russians informed of scientific developments in this country.

After the war the society hopes to promote the exchange of students and scientists and to sponsor study tours in the two countries.

Dr. Walter B. Cannon, professor emeritus of physiology, Harvard University, and a member of both the National Academy of Sciences of the United States and the Academy of Sciences, U.S.S.R., is president of the group. Dr. Henry E. Sigerist, director of the Institute of the History of Medicine, Johns Hopkins University, is editor of the *American Review of Soviet Medicine*.

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Vol. 61, No. 1, July 1943

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California Nurses Adopt Schedule of Salaries and Personnel Practices

A new schedule of minimum salaries and personnel practices for institutional nurses was recently adopted and distributed by the California State Nurses' Association as a sequel to the association's previous work to improve the economic position of its members.

For a general staff nurse, the minimum entrance salary is given as \$155.25 cash per month without maintenance. Tenure of service increases are provided of \$2.50 per month every six months

until the salary reaches \$170.25 per month.

The association states that nurses "shall not be required to take more than one meal a day in the hospital dining room; the nurse shall have the privilege of designating which meal she shall take. The charge to be made by the hospital for this daily meal shall not exceed \$10 per month, provided the salary of the nursing staff remains the same as set forth in this schedule."

If other meals are taken they shall be at the same rate. The hospital shall not deduct more than \$10 for meals unless the nurse formally arranges to purchase more than one daily meal.

The nurse is given the privilege of deciding whether she wishes a room. Rental shall not exceed \$10 per month. Similarly, laundry service may be accepted but shall not cost more than \$5 per month and shall include not less than three uniforms per week.

Two weeks' vacation with pay annually is required, with one day vacation for each month of employment up to twelve months but no vacation for less than six months' service. Terminal vacations are to be granted on request after twelve months' continuous service. Sick leave arrangements are the same as vacation, but are not cumulative.

A free health examination should be given before employment and annually thereafter and should include a fluoroscopy of the chest and a Wassermann. Health conservation service should be provided and hospital insurance is strongly recommended. Health records should be confidential but reports should be given to the director of nursing service.

An eight hour day and a six day week are provided, but provision is made for split shifts if necessary. Six holidays are recognized. Time schedules and days off should be posted one week in advance. Overtime of thirty minutes or more is to be recorded and made up to the nurse within thirty days.

Staff nursing of less than fourteen days is to be considered relief and paid for at private duty rates. Both the nurse and the hospital should give fourteen days' notice of termination of permanent employment and seven days' notice if employment is temporary.

For directors of nurses in hospitals without nursing schools the salaries are to be \$235.75 without maintenance; for assistants to the director, \$207; for supervisors, \$189.75; for head nurses, \$184 if they have academic degrees and \$172.50 otherwise. In hospitals with nursing schools, the director is to receive \$281.75 without maintenance; the assistant principal or supervisor of instruction, \$237.75; the teaching supervisor, \$201.25; the instructor, \$201.25. Maintenance arrangements and personnel practices are to be the same as for general staff nurses.

Chronic Illness Study Available

A limited number of copies of "Chronic Illness in New York City," by Mary C. Jarrett, is available for distribution from the Welfare Council of New York City. The only charge made for the two volume study will be for wrapping and mailing, amounting to about 20 cents.

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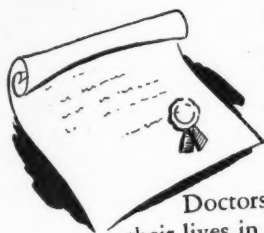
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OFFICIAL ORDERS

May 15 to June 19

W.P.B. ORDERS

Batteries.—More flexible control over production of dry cell batteries and portable electric lights operated by dry cell batteries was established by W.P.B. in the amendment May 21 to Order No. L-71. Base period quotas have been eliminated and production placed on a scheduled basis. Beginning July 1, manufacturers will follow new production schedules. Production of multiple batteries using small cells is permitted but manufacturers still are prohibited from transferring such batteries for use in the ordinary type of portable radios. They may be sold for use in scientific and therapeutic instruments.

Coffee Urns.—To clarify the status of the coffee urn in commercial cooking and food and plate warming equipment, subparagraph (a) (1) section 3036.1 of Limitation Order L-182, was amended June 5 to read: "commercial cooking and food and plate warming equipment" means equipment (except equipment specially designed to use electricity as the heating agent) designed for heating kitchen utensils or plates, or for cooking or baking food for consumption or sale on the premises in which the equipment is located." Coffee urns are thus included in this order irrespective of the heating agent to be used, except where the urn has an electrical unit as an integral part of the equipment.

Fiber Door Mats.—Production was cut off by order M-312 effective June 16, putting coir under restrictive controls. Consumption of coir is now limited to military orders or those bearing a rating of AA-5 or higher.

Priorities.—AA-2 rating was restored by amendment of Priority Regulation No. 1 on June 9. It falls between AA-1 and AA-2X and provides increased flexibility to the priorities structure.

Refrigerating and Air Conditioning Equipment.—Purchase orders for maintenance and repair parts for industrial and commercial refrigerating and air conditioning equipment must bear preference ratings of AA-5 or higher according to an amendment to Order L-38 issued on May 28. Previously an AA-4 was required.

O.P.A. ORDERS

Food.—Industrial container sizes of frozen fruits and vegetables, i.e. over 10 pounds, which were "ration free," were brought under control of the rationing program by O.P.A. on June 6. Hospitals and other Group II and III institutional users may sell or transfer excess inventories of rationed foods, according to an amendment to G.R.O. 5 issued June 14, with the permission of the local ration board and at current point values. The points obtained may not be spent but must be turned in to the local rationing board within five days of the date of sale.

Gasoline.—A complete revision in the list of activities to be accorded preferential treatment in the Eastern gasoline shortage area puts hospitals, medical supplies, hospital supplies and service in the A-1 (very critical) class, according to an announcement by the O.D.T. on June 7. Trucks servicing these industries should be supplied with gasoline for necessary truck transportation.

Neoprene Syringes, Catheters and Similar Rubber Drug Sundries.—Temporary manufacturers' ceiling prices on these items were established by O.P.A. on May 26. These ceilings will expire on September 20.

WAR MANPOWER COMMISSION

Employment Stabilization Plans.—Machinery for appeals by employees and employers from W.M.C. action under employment stabilization plans, the 48 hour week and other regulations was set up on May 23 by W.M.C. Chairman McNutt with promulgation of Regulation No. 5.

WAR LABOR BOARD

Wage Brackets.—Minimum and maximum wages for 72 job classifications were established in Chicago area by the regional W.L.B. on June 7. The categories of interest to hospitals and the weekly wage for 40 hours are: office boy or girl, \$18-\$22; file clerk I, \$20-\$32; file clerk II, \$18-\$24; general office clerk, \$22-\$30; clerk I, \$27-\$45; clerk II, \$22-\$35; clerk III, \$18-\$24; general bookkeeper, \$27-\$36; typist I, \$22-\$32; typist II, \$20-\$28; typist III, \$18-\$24; stenographer I, \$22-\$40; stenographer II, \$20-\$33; stenographer III, \$19-\$27; secretary, \$23-\$50; switchboard operator, \$22-\$33.

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Dyphen has high germicidal efficiency—low toxic effect—has a *phenol coefficient of 7* (FDA Method). It is soluble in water, alcohol, chloroform, and glycerine and retains its strength indefinitely. It is non-specific in action and can be used practically any place a germicide or antiseptic is needed.

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Calvin's Election as Minnesota President Contested by Stasel

Because of a conflict over interpretation of the articles of incorporation and by-laws of the Minnesota Hospital Association, the association was not able to decide on a president-elect at the convention held May 23 to 25 and had to hold this decision for a mail ballot.

Arthur M. Calvin, executive director of the Minnesota Hospital Service Association and for many years executive secretary of the hospital association, was nominated as president-elect by the nom-

inating committee headed by Dr. Peter D. Ward. A. G. Stasel of Eitel Hospital objected on the ground that Mr. Calvin is not a hospital administrator and that, being a type IV member, he is not eligible to hold office. Because only one member of the constitution and rules committee was present, Dr. Walter P. Gardner, president, refused to pass on the constitutional question.

Other officers elected were: Diana Bremness of Glenwood Community Hospital, Glenwood, first vice president; Sister Viola, St. Gabriel's Hospital, Little Falls, second vice president; Nellie Gorgas, St. Barnabas Hospital, Minneapolis,

treasurer. Rev. L. B. Benson, Bethesda Hospital, St. Paul, was installed as president.

The association went on record in favor of limiting all officers and trustees of the American Hospital Association to a single term (no mention being made of the various councils) and conferred an honorary membership upon Dr. Bert W. Caldwell.

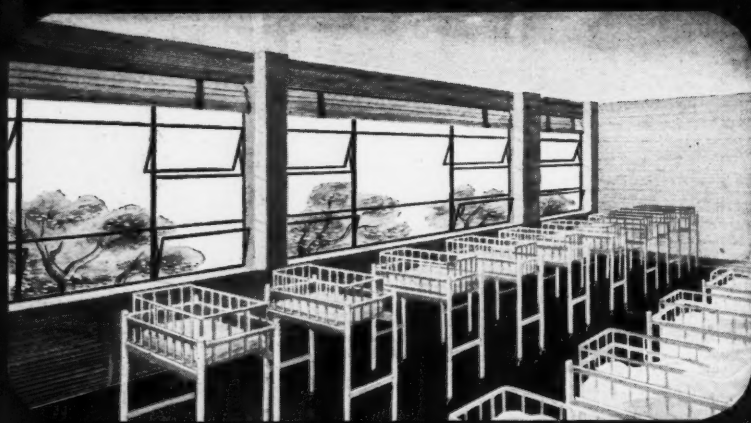
One of the outstanding events of the convention was the report of a special committee for better nursing service in rural communities. This committee, which included representatives of the medical, nursing and hospital associations and the state board of nurse examiners, recommended short courses for paid auxiliary workers in hospitals and in homes. A definite program for the training of such workers was outlined.

It is recommended that these workers be at least 17 years old, citizens, that they have had two years of high school work if now under 25 years old or have completed the eighth grade if older, and that they be of good character and health. It is also recommended that they work a forty-eight hour week. Tuition for the course of nine months would be \$10, with pay at the rate of \$10 per month for the last three months.

Hospitals undertaking this training program should have at least 25 beds and an average daily occupancy of at least 20 patients. There should be at least one instructor assisted by physicians, dietitians, public health nurses and others. Hospitals should not accept more than two classes per year, the size of the classes to be determined by the needs of the hospital and the community.

These workers should be granted certificates, the committee recommended.

Your Postwar Hospital Planning should provide **SUNSHINY** and **CHEERFUL ROOMS**



This means that your fenestration of postwar hospitals should call for larger window areas. Then your hospitals will meet the new trend which indicates windows built of metal with slender frames and large glass areas to flood every room with daylight and good cheer.

There are many other advantages to be gained by using Fenestra Hospital Window Specifications, such as, better ventilation—easier opening—superior weather-tightness—safer washing—increased fire safety and lower cost—by America's oldest and largest peacetime manufacturer of solid-section steel windows.

DETROIT STEEL PRODUCTS COMPANY
Now Engaged Exclusively in War Goods Manufacture
Dept. MH-7, 2255 East Grand Blvd., Detroit, Mich.
Pacific Coast Plant at Oakland, California

Fenestra suggests—have an architect start plans now.



St. John's Hospital, Springfield, Ill.
Henry R. Helmle, Architect;
J. L. Simons Co., Contractors

Fenestra POSTWAR HOSPITAL Windows

U. S. Court of Appeals Rules Against Hospital, Physician

WASHINGTON, D. C.—The U. S. District Court of Appeals on June 14 reversed the decision of a lower court in favor of the Eastern Dispensary and Casualty Hospital, Washington, D. C., and Dr. Joseph Russell Young, a physician in the hospital, defendants in a malpractice case.

The court of appeals declared that the district court erred when it instructed a jury to consider only the expert testimony of physicians to the exclusion of all other evidence in the case.

The defendants were charged by Mrs. Callie Byrom with malpractice in connection with the treatment of a wrist injury sustained in 1938. Mrs. Byrom sued for \$25,000, charging the wrist had never healed properly. Her husband also sued for \$5000 on the grounds that he had been deprived of his wife's services and society.



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dry
skins...

SOOTHING lanolin of top U.S.P. quality—combined with exceptional mildness—makes Williams Lanolin Soap worthy of your attention in cases of dry skin.

Only the finest grade oils are used in Williams Lanolin Soap—and in a way that precludes rancidity. It contains no fatty acids, no dyes, no strong perfumes. Uncombined alkali is virtually non-existent.

Because Williams Lanolin Soap is subjected to extremely high pressure, it is long-lasting, and economical. It lathers quickly into rich, creamy suds—rinses completely. Lightly scented and tastefully wrapped, it has the appeal of an

extremely fine complexion soap.

In order that you may observe its qualities in actual use, we'd like to send you a full-size cake of Williams Lanolin Soap. Of course, there's no obligation. Just mail the coupon.

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The J. B. Williams Co., Dept. SB-08
Glastonbury, Conn.

Please send me a full-size cake of Williams Lanolin Soap.

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Address _____

City _____ State _____

This offer is limited to the medical and nursing professions. Please attach letterhead, card or other professional identification. Good only in U. S. A.

War Department Lists New Hospital Construction for May

WASHINGTON, D. C.—The War Department announced the following hospital construction in May:

May 25, hospital facilities in Orange County, New York, costing less than \$50,000; contract awarded to John F. Meehan, Inc., New York City.

May 26, hospital facilities in Okaloosa County, Florida, costing between \$100,000 and \$500,000; contract awarded to Algernon Blair, Montgomery, Ala.

May 26, hospital buildings and facilities in Umatilla County, Oregon; con-

tract awarded to Brennan and Cahoon, Pendleton, Ore.

May 28, conversion of the Pilgrim State Hospital, Brentwood, Long Island, N. Y., for use as an Army general hospital, costing in excess of \$1,000,000; supervised by the New York district office of the Corps of Engineers.

June 3, hospital facilities in Knox County, Illinois, costing in excess of \$2,000,000; contract awarded to A. Farnell Blair, Decatur, Ga.

June 3, hospital facilities in Cook County, Illinois, costing approximately \$5,000,000; supervised by the Chicago district office of the Corps of Engineers.

June 15, Army General Hospital in Henrico County, Virginia, costing in excess of \$1,000,000; supervised by the Norfolk office of the Corps of Engineers.

On June 19 the Navy Department Bureau of Medicine and Surgery confirmed the report that the Navy is taking over the Sun Valley resort in Ketchum, Ida., as a convalescent hospital. Capt. Carlton L. Andrus said that the hospital would have 1400 beds and would soon be in operation.

A teletype message June 19 indicated that the Army Air Force Technical Training Command will begin in mid-July to relinquish about half of the hotels and other civilian properties temporarily taken over to house military personnel. Of 434 hotels, the messageran, 206 will be turned back. Facilities that have been converted into military hospitals will not be affected.



Where CLEANLINESS COUNTS!

Remove the threat of food contamination by using an insecticide formulated for safe use around foodstuffs.

An ordinary "fly spray" won't do! Why? Because two factors are involved that prohibit its use—Food Contamination and Kill Power.

A Food Insecticide must not impart any odor or taste, even if the spray should come in direct contact with the food—nor should it adversely affect cooking or baking characteristics.

Then too, a Food Insecticide must be designed to kill those tougher insects (cockroaches, weevils, etc.) as well as flies.

Further, it must be absolutely non-toxic to humans and create no fire-hazard.

You will obtain all of these characteristics AND MORE in

MILLO-Cide

LINE OF FOOD INSECTICIDES

MILLO-CIDE has long been a favorite insecticide of Millers, Processors of Food, Wholesale Grocers and other handlers of edibles where the control of food insects is a major problem.

Write the Food Insecticide Division of MIDLAND LABORATORIES —NOW—for aid in the establishment of adequate insect control measures in your institution.

MIDLAND Laboratories

DURHAM, N. C.

Ranks of Dietitians, Physical Therapists Outlined by Army

WASHINGTON, D. C.—Just distributed by the War Department is a new Army regulation that lays down general provisions governing the new corps of dietitians and physical therapy aides in the medical department.

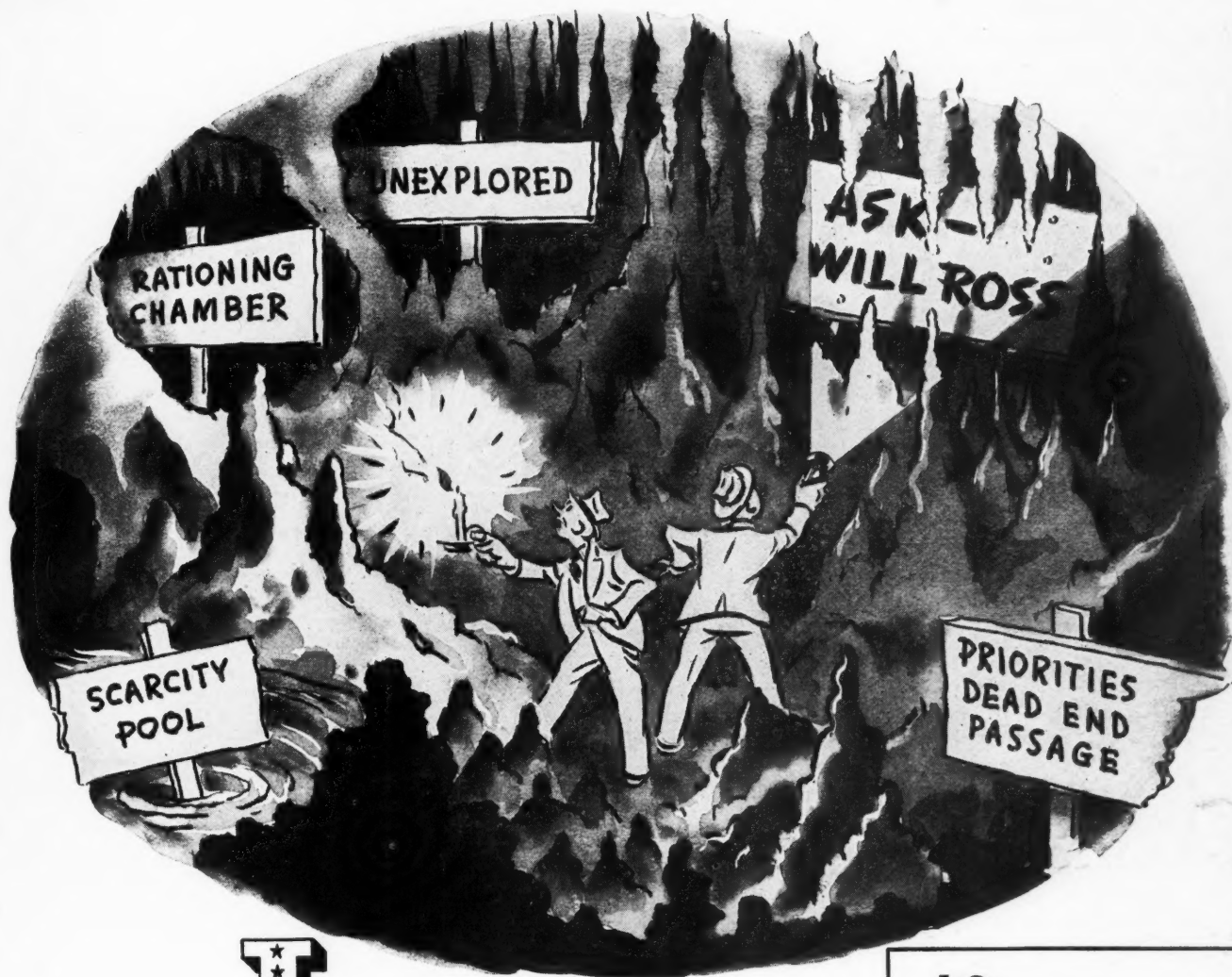
The regulation states that original appointments in either corps must be in relative rank of second lieutenant, with the exception of civilian dietitians and physical therapists who have previously served with the medical department.

The first assignment of a dietitian or physical therapy aide will ordinarily be made to a station in the United States so that the appointee can become familiar with military and medical department procedures.

The director of each corps, with relative rank of major, will be designated by the Secretary of War to serve for a four year term. Reappointments may be made. If not redesignated, the directors may, at the discretion of the department, continue on active duty as chiefs of hospital dietitians or physical therapy aides, with relative rank of captain.

Voegtlin Retires From U.S.P.H.S.

A portrait of Dr. Carl Voegtlin, 64, retiring chief of the U. S. Public Health Service's National Institute of Health, was accepted for the institute by Dr. Thomas Parran, surgeon general, on June 7. In delivering his final report before the National Advisory Cancer Council at Bethesda, Md., Doctor Voegtlin reviewed the work carried on at the national research center of which he has been head since its inception in 1937. Dr. Roscoe R. Spencer, assistant chief of the institute, has been named successor to Doctor Voegtlin.



IN deep? Confused occasionally? Who isn't? There are lots of blind passages these days. And plenty of unexpected things to stub our toes against or knock the skin off our shins. It's all part of the price we pay to preserve the right to make our own mistakes — Democracy's gift to a nose-led world. ☆ When you feel lost, holler. We'll hear you. We've done quite a little exploring. And even if we don't know all the answers, we have been relatively successful in helping others out of tight spots: So, always, ask Will Ross.

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Quality Hospital Supplies

18 SPECIALIZED DEPARTMENTS



Surgical Dressings
Instruments
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Tuberculosis Sanatorium
Supplies
Maternity Supplies
Furniture
Equipment for Surgery and
Operating Room
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A.H.A. Trustees Affirm Buffalo Meeting; Cancel Accounting Institute

Opposition to the portion of the Wagner-Dingell social security bill that deals with hospital service to insured persons if the provisions are found to be inconsistent with the "six-point program" of the A.H.A. or with the Bishop resolution was voted by the association's trustees meeting in Chicago on June 3 and 4.

The action was made conditional because copies of the bill had not yet been received by the association. The trustees carefully limited their opposition to the

sections dealing with hospital service to insured persons, since other sections of the bill doubtless will win support from hospitals.

Another important action was a request to the American College of Hospital Administrators to consider taking the responsibility for direction of the institute for hospital administrators at the University of Chicago. This institute has been conducted by the A.H.A. since 1933, with the A.C.H.A. as a joint sponsor.

The trustees affirmed their decision to proceed with the Buffalo convention next September. Dr. Frank Bradley of St. Louis was appointed chairman of the

council on hospital planning and plant operation and other new members appointed to this council are Dr. Albert W. Snoke, Rochester, N. Y.; Ray Bodwell, Cleveland, and William Rich, Durham, N. C.

The accounting institute was canceled for this year. The trustees accepted a grant of \$5500 from the Research Committee on the Problems of Alcohol to make a study in this field and appointed Dr. E. M. Bluestone, Dr. Claude W. Munger and Dr. Robin C. Buerki to represent the association.

Approval was given to several other new projects. A report on desirable increased services by the association and means of financing them was approved. The committee on coordination of activities was appointed as the editorial board of *Hospitals*.

The executive secretary was authorized to employ a new librarian for the Bacon Library to succeed Janet M. Green, who retired on January 1.

FREE!

4½-Ounce Bottle of VITALOX



Armour's
New Kitchen Discovery
that Adds Meat Flavor
to Your Dishes!



Discover... at Armour's Expense
...how Vitalox Adds New Flavor
to Meats, Stews, Gravies and Soups. It's Rich,
Flavorful Beef Extract... plus Vegetable
Extract, Tomato Juice and Zestful Spices
... Yours without a Ration Stamp!

Discover Vitalox! Learn how this new rich blend of beef extract, tomato juice and spices adds flavor to your favorite recipes. It livens up all meats... makes hearty brown gravies... wakes up the taste of soups and stews. One teaspoonful to a cup of hot water makes a delicious, clear soup. The cost?... About a penny per serving.

A 4½-ounce bottle is yours Free to prove the goodness of Vitalox.

When you've discovered what Vitalox can do for your bill of fare, order a supply of one-pound bottles from your local Armour Branch or jobber.

TRADE **VITALOX** MARK
ARMOUR'S NEW KITCHEN DISCOVERY
Armour and Company



MAIL COUPON TODAY!

Free offer made solely to acquaint Chefs and Dietitians with Vitalox... now available in the Economy 16-ounce bottle.

ARMOUR AND COMPANY, Chicago, Ill.
Yes, I want to try Vitalox at Armour's expense. Send me a FREE 4½-oz. bottle. all 7-48

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Address _____
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Chinese Hospital Set Up Inside Caves Dug Out of Loess Cliffs

A hospital tucked safely away inside a loess cliff is China's answer to the Japanese penchant for bombing hospitals. The entire Bethune Memorial Peace Hospital in Yen-an, in the guerrilla northwest territory, is built in caves that are divided into wards for surgical, medical, communicable disease and obstetrical cases.

Each cave is like an outside tunnel with a semicircular roof and measures 22 by 10 by 10 feet. Each has washable semicement floor, glass-screened windows and plastered walls and ceilings. Heat for the hospital is generated by a system of coal-heated tunnels under the floor that provide a temperature of 60°F. in winter. Ventilation must be regulated by opening or closing tunnel doors.

Each cave holds five beds constructed of a trestle and two boards resting on a stone. The beds are fitted with grass mattresses, two sheets, a cotton quilt and pillows. There is never enough bedding in winter and so patients are asked to bring their own.

Doctors and nurses in this and all hospitals in the northwest territory live according to military discipline. Nurses live in barracks-like quarters inside cave rooms, clean their own quarters, carry water for washing and work in the vegetable and flower gardens.

Even the patients have responsibilities, it is reported by the China Aid Council, a participating agency of United China Relief. They elect representatives to present their suggestions and opinions on the hospital management and contribute talent to hospital entertainments.



"See—There's No Shadow"

Watch a major operation that is being done under a Castle Light. Notice that even when the surgeons' heads almost touch under it, more than enough light gets by to light the deepest cavity adequately.

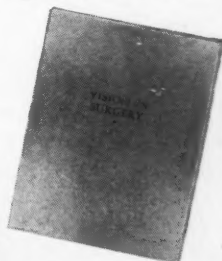
Projecting the light from a wide area and from many angles, the Castle Light is built to avoid shadows result-

ing from this common occurrence. There's no neck-reddening heat either, because of its special heat filters.

From every angle it's the kind of light a surgeon likes . . . the kind of light he can forget when he's working under it.

WILMOT CASTLE COMPANY, 1271 University Ave., Rochester 7, N. Y.

CASTLE LIGHTS



Write for your Copy—
"Vision in Surgery"

Merger of New York, New Jersey Meetings Declared Successful

Unusual interest centered upon this year's meeting of the Hospital Association of the State of New York and the New Jersey Hospital Association, which was held in New York May 26 to 28.

The success of the merger was measured by substantial audiences that taxed the capacity of the hall and by the interest evidenced in the talks and discussions. War or no war, it is likely that in future the two groups will continue this happy yearly affiliation.

The sessions opened with a frank statement by Msgr. Maurice F. Griffin, senior trustee of the American Hospital Association, to the effect that voluntary hospitals are on the defensive today. They are fighting for their lives under the proposed new social security legislation. "This particular benefit is no Santa Claus, as many think," he protested. The fundamental question as he sees it is our attitude toward the sick. "Is it humane or economic?"

Endorsement of hospital plans, such as the Blue Cross, was expressed by James A. Hamilton, president of the American Hospital Association, as one

of the most effective ways of combating the trend toward federal control of hospitals.

The various sessions gave the hospital executives the opportunity of becoming better acquainted with their representatives stationed in Washington and being brought up to date on matters pertaining to priorities and rationing. The representatives included, among others, Everett W. Jones, head hospital consultant, Governmental Division, W.P.B., and James Russell Clark, director of the War-time Service Bureau of the American Hospital Association in Washington.

Speaking on food rationing for the O.P.A., Martin A. O'Hara explained that the theory on which the government has operated is that "the consumer who eats in an institution, whether hospital or restaurant, should not have available for him more food than is available to the consumer who eats at his own table at home." He went on to say that the O.P.A. was not attempting to tell hospital people how to use their allotments for it believes the superintendents know best how to run their institutions and how to use ration points to the best advantage. He prophesied that even stricter food rationing will be put into effect when German-occupied countries are liberated.

An equally discouraging picture was prophesied as affecting the fuel situation. The Petroleum Administration for War is willing to exempt individual hospitals and welfare institutions from the order to convert heating units from oil to coal, according to Mark Anton, but the institutions may regret such leniency next fall. "There just isn't going to be enough," was his frank comment.

Speaking on the nursing situation, Mary E. Manley, director of the division of nursing of the New York State Department of Hospitals, urged the use of paid volunteers "from the ranks of licensed and practical nurses and hospital attendants. She advocated the development of schools of practical nursing with high standards and impressed the audience with the fact that everything done now must carry over into peace times.

In meeting nonprofessional personnel problems, George Buck, superintendent of Mercer Hospital, Trenton, N. J., described what he sees as a golden opportunity to capitalize on the personnel program and make something out of it. "Try to make hospital work more important," he advocated. Another suggestion was that hospital heads get to know the top men in their local manpower commissions.

Serving as president of the New York State Hospital Association for the coming year is Harold A. Grimm of the Millard Fillmore Hospital, Buffalo. The New Jersey Group elected as president Dr. J. Berkley Gordon, Marlboro Hospital, Marlboro.

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Birth Certificate Service

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DUPLEX BIRTH CERTIFICATE FRAMES

PERFECTED FOOTPRINT OUTFITS

LONG-REACH SEAL PRESSES

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1200

HOSPITALS have adopted

our service in whole or in part. Maximum benefits

have resulted where the complete service is in

operation. Babies' footprints and mothers'

thumbprints, taken on the certificate, establish

identity. The official seal of the hospital

guarantees authenticity as a certificate of birth.

The duplex frame protects the certificate and assures permanent display in the home.

Send for free booklet

The story of the Hollister Birth Certificate

FRANKLIN C. HOLLISTER Company

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ON THE 'WAY OUT ~~IN~~ FRONT

Behind the thick growth of tropical forests or under the blazing sun of Africa's desert—wherever you find a hastily erected base hospital, there also you will find modern surgical equipment. Equipment that has been proven through years of service and research to be faithful to the trust that must be placed in it. Equipment that must be ready at all times, under all circumstances, in any kind of weather, to give its full quota of support to the tireless efforts of the service doctors and their staffs. For many years we who manufacture Wiltex Curved Finger Latex Surgeon Gloves have been very proud of the fact that these Gloves were always "'way out in front"—but it gives us greater satisfaction to know that today, as in the last war, Wilson's Surgeons' Gloves are 'way out ON THE front doing their part of a mighty important job.

The **Wilson**

RUBBER COMPANY

THE WORLD'S LARGEST MANUFACTURERS OF RUBBER GLOVES

CANTON . . OHIO

Hospital Care Plans Liberalize Benefits, Approach Uniformity

Liberalization of benefits of Blue Cross plans was reported from many areas in a summary presented to the Hospital Service Plan Commission in June by C. Rufus Rorem, executive director.

"In New York City benefits have recently been expanded to remove monetary limits for the various special services. At Cincinnati, a comprehensive contract has been developed and approved for adoption in the autumn; liberalization has been obtained in Los

Angeles, San Francisco and St. Louis. At Columbus the principle of a comprehensive contract has been approved and a movement is under way for its adoption. In the Akron plan the principle of comprehensive benefits has been endorsed and a subcommittee of the board has been appointed to consider methods of application.

"The Blue Cross plan in Harrisburg has adopted the comprehensive contract in toto and now offers to its subscribers complete hospital care for all types of illnesses.

"The most significant effect of the uniform contract," Mr. Rorem contin-

ued, "appears to be stimulus to expansion of benefits, both as to type of service and to type of illnesses protected. As benefits approach completeness in their character, they will, by definition, also approach uniformity, which will serve as the basis for expanded reciprocal procedures and unified dealing with national employers and the American public."

Although Mr. Rorem reported that more harmonious relations were being established with the American Medical Association, the house of delegates of the A.M.A. vigorously attacked the uniform contract, as reported elsewhere this month.

John H. Hayes Heads Greater New York Hospital Group

Officers of the Greater New York Hospital Association elected at its annual meeting held May 21 in New York are: president, John H. Hayes, superintendent, Lenox Hill Hospital; first vice president, Dr. Morris Hinenburg, Jewish Hospital of Brooklyn; second vice president, Dr. Frederick MacCurdy, commissioner, New York State Department of Mental Hygiene; secretary, William B. Seltzer, superintendent, Bronx Hospital, New York City, and treasurer, George F. Holmes, superintendent, Memorial Hospital, New York City.

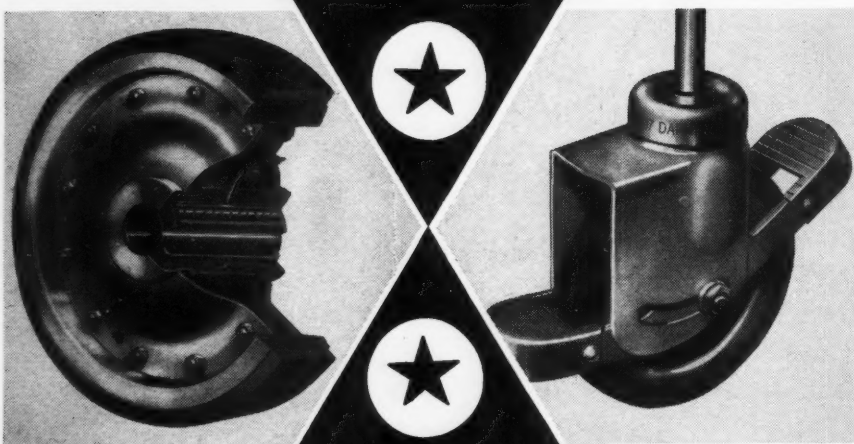
Addressing the hospital group, Mayor Fiorello H. La Guardia urged hospital superintendents to start preparing for both social and economic changes, emphasizing that the middle classes are in a precarious position, the very poor and very rich being assured of good medical and surgical care. It is the mayor's plan to provide medical, surgical and hospital care for everyone. Taxes will continue to be high, in his opinion, with the result that hospital contributions that are deductible from taxes should be good. He looks to the day when New York City will be the medical and surgical center of the world.

In describing the campaign of the Greater New York Fund, W. Randolph Burgess indicated that experience had shown that the best selling point for hospitals is in the obstetrical service rendered.

South Carolina Elects

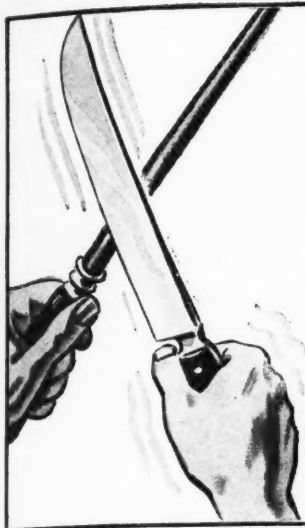
New officers elected for 1943-44 at the annual meeting of the South Carolina Hospital Association, May 26, are as follows: president, J. B. Norman, Spartanburg General Hospital, Spartanburg; president-elect, Dr. V. P. Patterson, Pryor Hospital, Chester; first vice president, Katherine O. Altman, Marion Sims Memorial Hospital, Lancaster; secretary-treasurer, R. L. Dougherty, Orthopedic Hospital, Columbia.

.. Demand **DARNELL** *Casters & Wheels*



Darnell Double Ball-Bearing Casters and E-Z-Roll wheels reduce floor wear to a minimum, lengthen the life of equipment and increase the efficiency of employees—Write for 192 page Darnell Caster and Wheel Manual.

DARNELL CORP. LTD., 60 WALKER ST., NEW YORK, N.Y.
LONG BEACH, CALIFORNIA, 36 N. CLINTON, CHICAGO, ILL.



NEW CHART

TELLS HOW TO GET MORE SERVINGS FROM ROASTS

Is excessive shrinkage caused by overheated ovens cutting down the number of servings you should be getting from your roasts? It's possible these days when you must depend on inexperienced help and it happens when you can least afford waste. So this new instruction chart for operating roasting ovens equipped with Robertshaw Thermostats can be of real value to you.

It gives important information on causes and control of meat shrinkage. It has a complete time and temperature chart telling how to roast practically every cut of meat to get the most servings. It also tells how to operate the thermostat to get correct oven temperatures without guessing.

This roasting chart is included in the set of five charts which you can get for only twenty-five cents the set — just enough to cover printing and mailing costs. In addition to the roasting chart the set includes helpful charts for steam tables, bake ovens, deep fat



fryers and coffee urns. Each chart is 10" x 15", printed in two colors on durable cardboard. Send for your set today, using the handy coupon below.

ROBERTSHAW THERMOSTAT CO.

MH2

30 Church St., New York, N. Y.

Please send me the set of five instruction charts to help me teach inexperienced employees how to save food and fuel. I enclose twenty-five cents to cover printing and mailing costs.

Name _____

Firm Name _____

Street _____ City and State _____

ROBERTSHAW

Hospitals Are Warned Against Swindler With Telephone Book Racket

Purchasing advertising space on a telephone book cover that has never materialized will probably cost the Hospital Service Association of New Orleans \$213.75, with no return on its investment, it has been reported by Edward Groner, manager, who has issued a warning to hospitals and hospital equipment and supply houses to be on the lookout for a swindler.

Four months ago a man calling himself James T. Williams called upon Mr.

Groner and informed him that he was selling advertising space on a telephone book cover that would be distributed to hospitals. Prior to calling on the Hospital Service Association he had approached the Hotel Dieu in New Orleans, exhibiting his sample telephone book cover and advising that the hospital would be furnished 20 or 25 covers without charge because advertising would cover the cost. He then obtained a letter from the hospital addressed "To whom it may concern," outlining the procedure and stating that he was authorized to solicit for them.

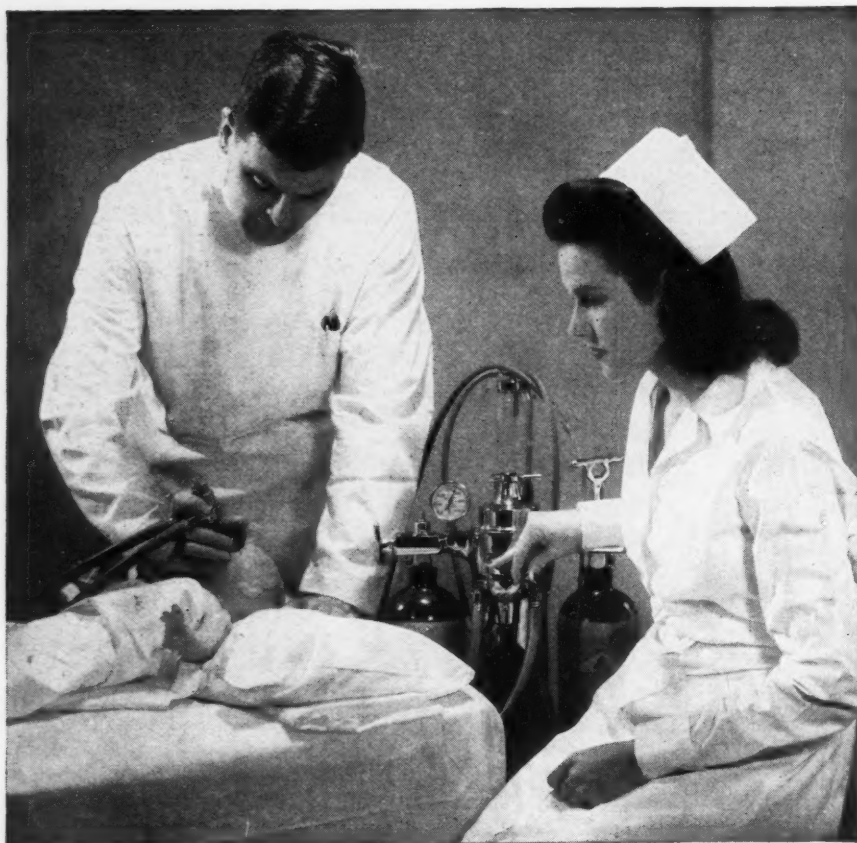
Feeling that the covers would provide

a good advertising medium and an opportunity to cooperate with the hospitals, the Hospital Service Association contracted for cover space for three of its largest hospitals. The check was made payable to the Builders Publishing Company and the salesman stated that covers would be delivered to Touro Infirmary in ninety days, or approximately April 15.

When the covers were not received, a letter was sent to the Builders Publishing Company, 9 South Kedzie Avenue, Chicago, and was subsequently returned marked "unclaimed."

A further check by Mr. Groner with the Better Business Bureau of New Orleans revealed that a report had been made that the same man had been operating in Houston, Tex., and had collected nearly \$400 in advance payments for advertising in a nonexistent "builders' guide."

The man is described as being about 45, 5 feet 8 inches tall, and weighs about 230 pounds. He has a dark complexion and brown eyes, wears glasses and is very talkative.



E & J

The Resuscitator of Proven Merit

For over seventeen years these automatic resuscitators have been saving lives. The E & J is safe to use and simple to operate—and above all—successful in the most desperate cases of asphyxia.

A large majority of the leading hospitals recommend the E & J Resuscitator for adults, children and infants in *Surgery, Obstetrics, Pediatrics and Emergency.*



E & J MANUFACTURING COMPANY

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Philadelphia

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Chicago

3900 Grandy Ave., Detroit

581 Boylston St.
Boston

M.G.H. Votes to Cut T.P.R.

Recording Unless Necessary

Curtalement of temperature recordings at the discretion of the physician was voted at a meeting of the general executive committee of Massachusetts General Hospital, Boston, recently.

It was decided that the visiting physician or surgeon should be asked to consider the necessity or advisability for daily T.P.R. recordings and to have these continued when in his judgment medical information would result.

In those cases in which the physician feels that such recordings are unnecessary, he should be empowered to omit them and if a single daily recording is sufficient, the doctor should specify the hour at which this should be taken.

The executive committee also voted to require the reviewing and rewriting of medication orders weekly, *i.e.* no medication should be continued beyond one week's time without the rewriting of the order.

Wesley's Story to Be Told

Wesley Memorial Hospital, Chicago, will be the subject of a feature article in the July 10 issue of the *Saturday Evening Post*. Entitled "Bedside Manor," the article will be written by Robert Yoder, columnist of the *Chicago Daily News*, and illustrated with colored photographs taken by the *Post's* roving photographer. The article constitutes a milestone in hospital publicity, according to Thaddeus Allen, public relations director of the hospital, and should be of interest to all in the hospital field.

Stop **EMPTY** CYLINDERS FROM BEING *Slackers*



HIDDEN away in closets and storage rooms are hundreds of empty gas cylinders, which, if they could speak, might say, "Put us to work—we're not slackers, intentionally."

It's up to you to keep empties returning to us so that present supplies meet present conditions. New cylinders are unobtainable for the duration... The only way by which we can keep the supply line of Ohio gases open to you is through the use of cylinders now in existence.

So—order gases in smaller quantities at more frequent intervals... return empties promptly and do not permit partially-filled cylinders to lie idle on infrequently-used equipment. Make a search *today* for slacker cylinders—tag them for shipment at once. You will do a good turn both to yourself and some other hospital or gas user, thus earning their thanks.

OHIO GASES

NITROUS OXID

ETHYLENE

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OXYGEN - CARBON
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ARE AVAILABLE

Their prompt shipment depends
upon the supply line of cylinders.



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Pioneers and Specialists in Anesthetics

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New Medical Teaching Program Inaugurated at Michael Reese Hospital

Michael Reese Hospital, Chicago, has announced the inauguration of a new program of medical teaching, developed at first on an intramural basis but gradually merging into postgraduate teaching available to the medical profession at large.

It is hoped that the program will be sufficiently advanced by the end of the war to help meet the demand for refresher courses for physicians now in the armed forces.

The part-time and full-time staffs of the clinical departments of the hospital, and the full-time staffs of the Research Institute and of the clinical laboratories will all be contributing members of the teaching faculty.

Dr. Herman Smith, who has been the general superintendent of the hospital, now becomes the executive director. Dr. Samuel Soskin has been appointed medical director and will be the dean of the teaching and research faculty. He has headed the department of metabolism and endocrinology at Michael Reese Hospital for the last fourteen years.

Baylor, Southwestern Foundation Disagree; Baylor Goes to Houston

Because of differences of opinion between the Southwestern Medical Foundation and Baylor University, Dallas, Tex., the latter's medical school is to be moved to Houston, Tex., and a new medical school under the foundation is being established in Dallas on the grounds of Parkland Hospital.

The differences arose because the foundation entered into a contract with Baylor University which apparently gave the foundation full control over the medical school to the exclusion of the university. Meanwhile the Anderson Foundation of Houston offered the university \$2,000,000 and 20 acres of land to move to Houston and the Houston Chamber of Commerce offered \$50,000 per year for ten years.

Many of the former Baylor faculty members have joined the staff of the new school in Dallas. The acting dean is Dr. Donald Slaughter, formerly assistant dean of the University of Vermont Medical School.

Advisory Service Instead of Exhibits Successful at C.H.A.

A national convention almost without any supplies or equipment in evidence was the unique experience of the Catholic Hospital Association meeting in Pittsburgh on June 11 to 14. Most of the officers were reelected, the only new one being the secretary, Sister Mary Agnes, St. Anthony's Hospital, Oklahoma City, Okla.

The association reiterated its stand on the Wagner Social Security Bill and similar federal legislation but Father A. M. Schwitalla, president, declared that Catholic hospitals are willing and prepared to take whatever steps are necessary to win the war. He foresees the possibility that some Catholic hospitals may be taken over by the government if there are many war wounded.

The technical advisory service that in large part replaced the commercial exhibit was declared to be a distinct success. The convention was cut from eight to four days, including the period of the hospital institute.

Granted Army-Navy "E"

Four manufacturers serving the hospital and allied fields have recently been awarded the Army-Navy "E" for excellence in production. They are: American Laundry Machinery Company, Norwood Station, Cincinnati; Pelton and Crane Company, Detroit; Scanlan-Morris Company, Madison, Wis., and Westinghouse Electric and Manufacturing Company, Mansfield Plant, Mansfield, Ohio.

THE *Luck* BONE SAW

ECONOMIZES TIME IN ORTHOPEDIC SURGERY

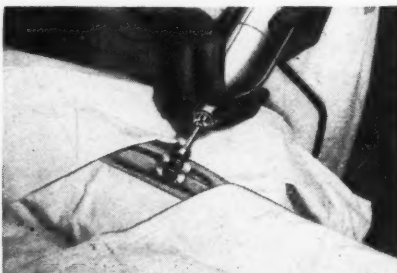
The necessity for strict economy of time, due to personnel depletion, is something every civilian surgeon recognizes today. The Luck motor-driven bone drill and saw has proved clinically that it helps to save time and labor.

There are two exclusive features. The complete motor unit and cord can be sterilized in autoclave. And the motor provides a high speed of 13,000 R. P. M. at the small end, while gearing reduces speed, 6 to 1, at the other end, to which the Jacobs Chuck is attached.

The high speed makes possible the use of very small diameter slotting burrs. The lower speed is ideal for inserting Steinman Pins and Kirschner Wires as well as sawing the bone. Variable speed is obtained by a foot controlled rheostat.



Used with slotting burr in making transverse end cuts during removal of bone grafts, after longitudinal cuts have been made with circular saws.



Used with twin circular saws. They rotate up to approximately 1500 revolutions per minute. Have great power. Do not jam or burn the bone. Second blade readily removed if only single blade is desired.



← The Luck Bone Saw in fitted case with complete equipment.

WRITE Zimmer today for further information, or complete catalog.

Zimmer

MANUFACTURING CO., WARSAW, IND.



In answer to your SOS

"Help us Save Our Soap!" . . . that's the plea of laundry operators everywhere. Precious war-curtailed supplies must be conserved, must be stretched to their fullest during these difficult days.

To meet this situation, Wyandotte stands ready with suggestions for making *less* do *more*. Out of their long experience with all aspects of washing problems, Wyandotte Representatives are able to recommend emergency measures that will do much to take the sting out of shortages.

Your methods, your local conditions are, of course, big considerations in finding the right solution. That's why Wyandotte men work so closely with laundry operators, pooling their knowledge with yours and prescribing only that which will be of personal and practical value to your plant.

Why not get together with the Wyandotte Service Representative nearest you? Call him in for a conference on soap short-cuts. By doing so, you may well discover the way to hurdle duration-limitations, maintain smooth washing routines, and keep the quality of your work top-notch.



Wyandotte

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J. B. FORD DIVISION • WYANDOTTE, MICHIGAN

• Wyandotte Chemicals Corporation consolidates the resources and facilities of Michigan Alkali Company and The J. B. Ford Company to better serve the nation's war and post-war needs.

Recommend Uniform Visiting Hours

A system of uniform visiting hours for all members of the Chicago Hospital Council has been submitted by a special committee for approval by the hospitals. The program, which covers general adult, obstetrical and pediatrics services—each subdivided into private, semiprivate and ward accommodations—involves a certain amount of curtailment of visiting. No effort was made to cover exceptions warranted by such situations as critically ill patients, visiting on the day of operation, or unusual working hours. It was felt that special individual arrangements to meet such prob-

lems should be made by the administrator or his representative.

Ohio Association Elects Officers

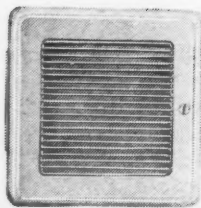
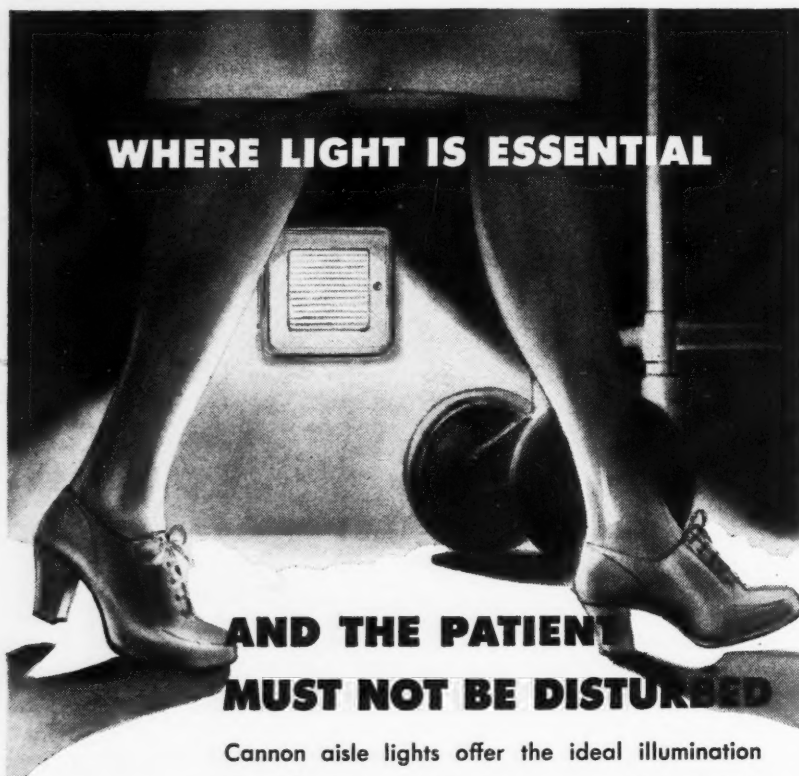
New officers named at the annual meeting of the Ohio Hospital Association are as follows: president-elect, Lee S. Lanpher, superintendent, Lutheran Hospital, Cleveland; first vice president, Agnes C. Hatch, R.N., superintendent, Chillicothe Hospital, Chillicothe; second vice president, Sister Mary Aquin, superintendent, Mercy Hospital, Toledo, and treasurer, Rt. Rev. Msgr. Maurice F. Griffin. Wilson L. Benfer, Toledo Hospital, Toledo, was inducted as president.

Vanport Builds Medical Center

The 40,000 residents of Vanport, the F.H.A. housing project located in the Portland, Ore.,-Vancouver, Wash., area, are now being served by a 135 bed infirmary known as the Vanport Medical Center. The building and equipment were furnished by the Federal Housing Authority as part of the housing facilities and the hospital is managed and staffed by Oregon Physicians' Service.

Medical Education Program Set Up

Arrangements have been made between the Medical College of Virginia and the West Virginia University Medical School whereby students from the latter at the completion of the two year course will transfer to the former. This arrangement is tentatively scheduled to go into operation next January.



Cannon aisle lights offer the ideal illumination for stairways, corridors and rooms where bright overhead lights would disturb the patient. Special lens of molded glass directs beams downward and gives a soft diffused light. So efficient is this unit that small lamps of 10 watt capacity are all that are required for ample illumination.

aisle light PL 10. Mounted flush with wall. Standard finish: Antique Ivory Enamel. Overall dimensions: 5 1/2" square x 1/2" deep. Wall opening: Standard 2 gang Plaster Ring on 4" square box.

Cannon Hospital Signal Systems comprise a complete line of ... Bedside Calling Stations • Nurses' Call Annunciators • Supervisory Stations • Corridor Pilot Lights • Doctors' Paging Systems • Aisle Lights • In and Out Registers • Explosion and Vapor-proof Switches • Elapsed Time Recorders.

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NAMES IN THE NEWS

Administrators

Dr. Donald M. Morrill of Detroit has been elected director of Malden Hospital, Malden, Mass., to succeed Shirley R. Mitchell, who has retired.

Bennett J. McCarthy has resigned his position as superintendent of Winchester Memorial Hospital, Winchester, Va. Beulah M. Brown will be his successor. Sarah Hamilton has been appointed director of the nurses' school and superintendent of nurses.

Dr. James Lewis has been named assistant superintendent of Westfield State Sanatorium, Westfield, Mass., succeeding the late Dr. Eliot H. Luther.

Kitty McKelvey is the new superintendent of St. Louis Maternity Hospital, St. Louis. She succeeds Mrs. Mary J. Keith.

Louis H. Putnam, superintendent of Overlook Hospital, Summit, N. J., has resigned. H. S. Turner has been appointed as his successor.

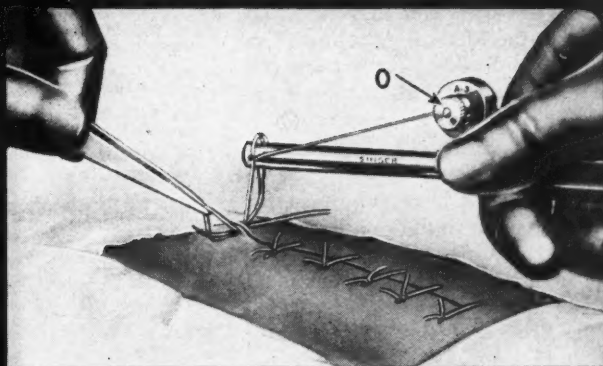
Frank Wilson is the new superintendent of Grady Hospital, Atlanta, Ga.

Sidney M. Bergman, executive director of Sinai Hospital, Baltimore, will assume the directorship of Montefiore Hospital, Pittsburgh.

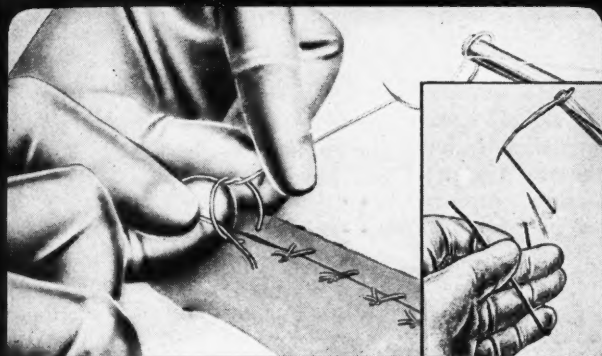
Dr. Karl H. Van Norman, superintendent of King County Hospital, Seattle, Wash., since 1932, resigned June 4 because of dissatisfaction with recent appointments to the board of trustees by the board of county commissioners. Following his resignation, Doctor Van Norman accepted the position of administrator of a new \$817,000 hospital to be constructed by King County Medical Service Corporation. A grant of \$617,000 towards the project has been made by F.W.A.

RAPID, SIMPLE FORMATION OF STITCHES

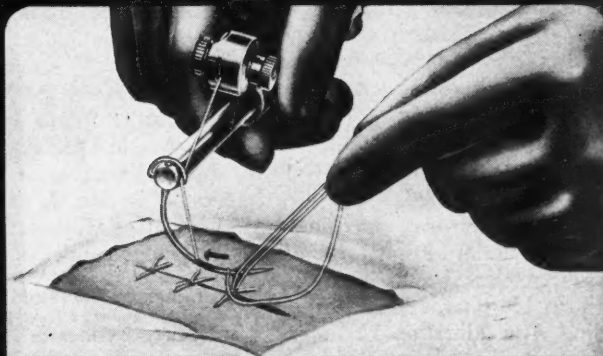
With Modern, Revolutionizing
Singer Surgical Stitching Instrument



Needle passed through tissue until loop of suture on needle can be picked up. With operator holding this loop needle is withdrawn while releasing thumb nut (a) to feed required suture length.



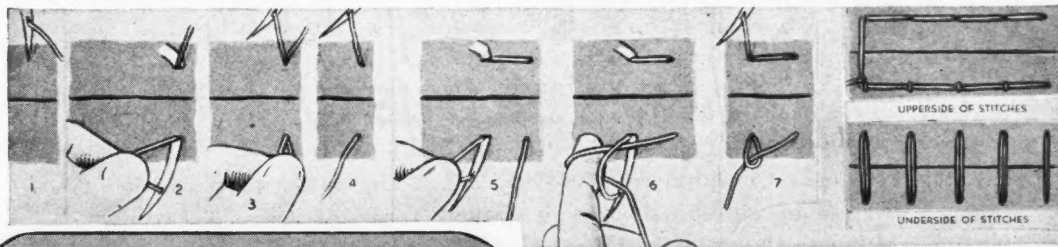
Suture may be tied either by assistant or with operator's one hand (inset). Owing to simple self-locking device, suture material on spool cannot unravel.



Suture quickly severed after each stitch by keen, knife edge of lance-point needle on Singer Surgical Stitching Instrument leaving it ready for next stitch without re-threading needle.

Surgeons are offered a variety of new and old interrupted and continuous stitches making possible accurate and rapid suturing with more complete closure and better postoperative patient comfort.

The Singer Surgical Stitching Instrument may be seen or demonstrated at your convenience at any of the Singer stores in larger cities throughout the country. Brochure will be furnished on request.



SINGER *Surgical Stitching* INSTRUMENT

The Singer Surgical Stitching Instrument is light and well-balanced. Since all parts are rust-proof it may be sterilized as a unit. After it is quickly taken apart for cleaning it may be reassembled in one minute.



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Alvin Langehaug, superintendent of Lutheran Hospital, Fort Dodge, Iowa, since 1937, has been commissioned first lieutenant in the Medical Administrative Corps. **O. A. Rusley**, former superintendent of schools at Lake Mills, Iowa, will fill Mr. Langehaug's position.

Ralph Judd Hromadka, superintendent of Santa Monica Hospital, Santa Monica, Calif., has been commissioned a second lieutenant in the Army Medical Administrative Corps. **Frank M. McBurney** will be acting superintendent during Mr. Hromadka's absence.

Ray E. Brown, former administrator of Shelby Hospital, Shelby, N. C., has been appointed the new administrator of North Carolina Baptist Hospitals, Inc., at Winston-Salem.

Harry Lieber has assumed the duties of assistant superintendent of Philadelphia General Hospital, Philadelphia.

Emma H. Lundbeck, superintendent of Brooklyn Thoracic Hospital, Brooklyn, N. Y., for the last eleven years, has resigned.

Virginia Berndt has resigned from the superintendency of the Westchester Square Hospital in New York City.

John T. Bath, former superintendent of Nesbitt Memorial Hospital, Kingston, Pa., has been elected superintendent of Bloomsburg Hospital, Bloomsburg, Pa., succeeding **Atta Albertson**.

Coming Meetings

Aug. 30-Sept. 10—A.H.A. Institute for Hospital Administrators, Knickerbocker Hotel, Chicago.

Sept. 8-11—American Congress of Physical Therapy, Palmer House, Chicago.

Sept. 9-10—Canadian Hospital Council, Chateau Laurier, Ottawa, Ont.

Sept. 11-12—American Protestant Hospital Association, Hotel Statler, Buffalo, N. Y.

Sept. 12-13—American College of Hospital Administrators, Hotel Statler, Buffalo, N. Y.

Sept. 13-17—American Hospital Association, Hotel Statler, Buffalo, N. Y.

Oct. 12-14—American Public Health Association, New York City.

1944

March 15-17—New England Hospital Assembly, Hotel Statler, Boston.

Mrs. DeMonte Newton, R.N., is the new superintendent of North Plains Hospital, Borger, Tex.

Maude M. Branscome, R.N., is the new superintendent of Mary Washington Hospital, Fredericksburg, Va.

Dr. Charles P. Fitzpatrick, superintendent of Rhode Island State Hospital for Mental Diseases, Howard, R. I., has resigned because of ill health. His successor is **Dr. John R. Ross**, superintendent of Hudson River State Hospital at Poughkeepsie, N. Y.

Department Heads

Mary Grimes is the new superintend-

ent of nurses at the Mohave General Hospital at Kingman, Ariz.

Kathleen F. Young has been selected as the new director of the school of nursing and nursing service at Grace Hospital, Detroit.

Gertrude Saper has been promoted to the position of purchasing agent at Mount Sinai Hospital, Chicago.

Miscellaneous

Dr. Frederick MacCurdy, professor of hospital administration at Columbia University and director of the Vanderbilt Clinic of the Presbyterian Medical Center, New York City, has been appointed commissioner of the New York State Department of Mental Hygiene.

William S. Brines, who has been acting chief of the hospital section of W.P.B., has been appointed chief of this section. In the absence of **Everett W. Jones**, head hospital consultant, Mr. Brines will have full charge of all activities pertaining to hospitals. Mr. Brines is on leave of absence as associate administrator of the House of Mercy Hospital, Pittsfield, Mass.



ISOPROPYL ALCOHOL (ANHYDROUS)

For general hospital use; for sterilization and antiseptic purposes and for rubbing alcohol compounds.

Although under allocation, one drum per month can be purchased outside of allocation under order M-168, as amended May 18, 1943. No permit or Government reports required.

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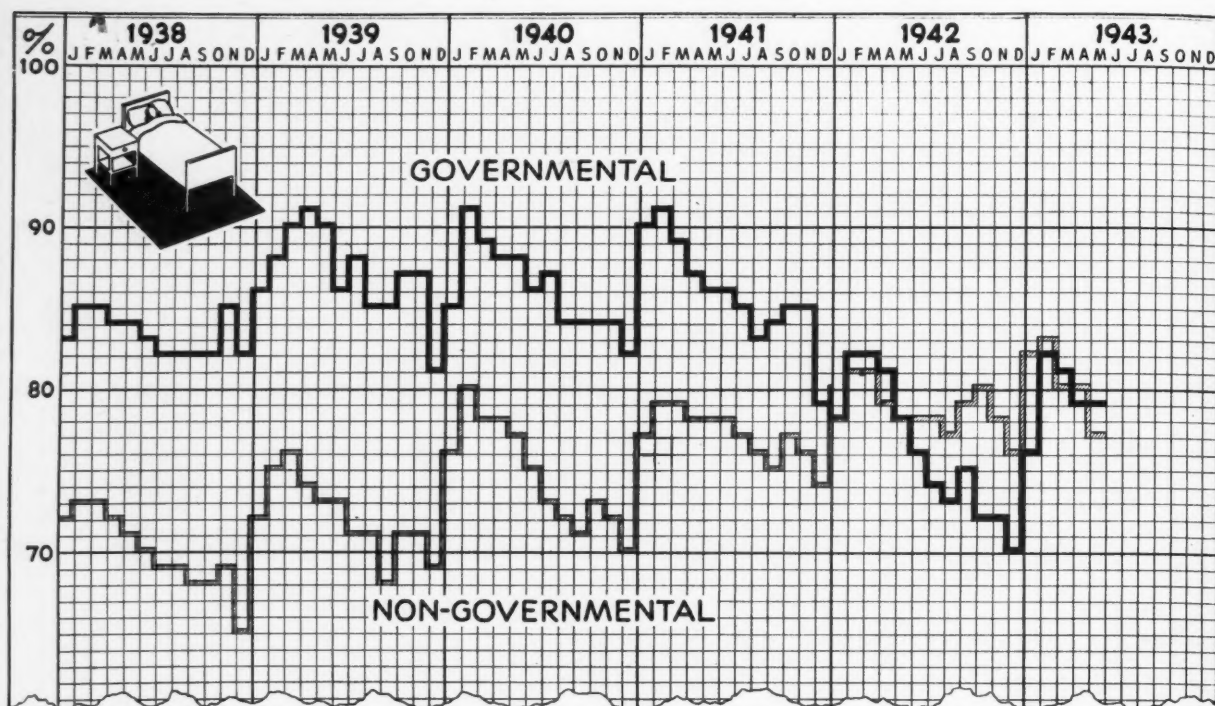
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CARITOL with Vitamin D Capsules
SMACO, bottles of 100
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Voluntary Hospital Occupancy Eases Off



Occupancy in voluntary hospitals dropped three points from the January-February peak of 82 per cent to a level of 79 per cent in May. During the same period the occupancy of governmental

general hospitals advanced to a peak of 80 per cent during March and April but dropped to 77 per cent in May.

A total of 18 new construction projects was reported from May 17 to June

14 with a total value of \$8,355,000. This brought the total since January 1 to \$74,895,000. Projects postponed during the same period had costs of \$18,723,700, leaving a net for the year of \$56,171,300.



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The proper maintenance of floors in Hospitals and Public Buildings throughout the Nation is of the most vital importance. Many floors in the past were needlessly worn out before their time thru neglect or the use of harmful materials. Today it is our duty to prolong the life of everything we have and Hillyard Floor Treatments and Maintenance Products properly used will add many years to the life of your hospital floors.

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